

# SAMPLE LETTER ONLY

## Letter of Medical Necessity - From Physician's Office

[Physician Letterhead]

**Date:** Current Date

**Patient Name:** [The Senior's Name]

**Date of Birth:** [Senior's Date of Birth]

**To Whom It May Concern,**

This letter documents the **medical necessity of in-home, supervised personal training services** for my patient, **[Senior's / Patient's Name]**, provided through **ElderFIT**.

The patient has age-related medical and functional limitations, including reduced strength, balance, and mobility, with an increased risk of falls and physical deconditioning. Due to these conditions, **unsupervised exercise or standard fitness programs are not medically appropriate**.

It is medically necessary that services be provided **in the patient's home** due to **mobility limitations and/or transportation challenges**, which increase safety risks and limit the patient's ability to attend facility-based programs.

I am prescribing **individualized, supervised personal training** delivered by a **certified trainer experienced in senior fitness** to improve strength, balance, and mobility; reduce fall risk; maintain independence; and prevent further functional decline. These services are part of the patient's medical care plan and **are not for general fitness or recreation**.

**Recommended Plan:**

Frequency: \_\_\_\_ times per week

Duration: \_\_\_\_ months

Location: In-home

Please contact my office if additional information is required.

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Physician Signature

**Physician Name, MD / DO**

License #: \_\_\_\_\_

Phone: \_\_\_\_\_