Letter of Medical Necessity (LMN) for Use of Hydro Air Treadmill Lab Facilities

Patient Full Name: _____ Patient DoB: _____

Patient Address: _____ Today's Date: _____

Medical Diagnosis (1 or more): _____
[Specify the diagnosed medical condition. Examples: Obesity (E66.9), Type 2 Diabetes Mellitus (E11.9), Chronic Lower Back Pain (M54.5), Osteoarthritis of the Knee (M17.1), Post-Surgical Rehabilitation (Z54.0).]

To the administrators of _____ [HSA Provider Name. Fidelity, HealthEquity, etc]:

This letter is to certify that I, the undersigned physician, have diagnosed _____ [Patient's Name] with the medical condition listed above. I have determined that a membership at **Hydro Air Treadmill Lab, LLC** is **medically necessary** for the **diagnosis, cure, mitigation, treatment, or prevention** of this condition. This is not for general health or cosmetic purposes.

Due to the patient's specific medical needs, traditional exercise is either not a safe or effective option. The specialized equipment and services offered at Hydro Air Treadmill Lab are required to affect a structure or function of the body, specifically to [select one or more from the list below and edit to fit the patient's needs]:

- **Low-Gravity Treadmill:**
  - Provide a low-impact environment for exercise to mitigate joint pain and reduce the risk of injury.
  - Facilitate weight-bearing exercise to improve bone density and muscle strength without excessive strain.
  - Aid in post-surgical rehabilitation by gradually increasing physical activity while minimizing stress on the healing area.
  - Assist in safe, controlled ambulation for individuals with neurological or balance disorders.
- **Water Treadmill (Hydrotherapy):**
  - Utilize the buoyancy of water to reduce stress on joints and aid in the treatment of arthritis or other degenerative joint diseases.
  - Improve circulation and reduce inflammation through hydrotherapy, which is essential for managing [e.g., neuropathy, lymphedema].
  - Support safe and effective cardiovascular exercise for individuals with mobility impairments.
- **Cryotherapy:**
  - Manage chronic inflammation and pain associated with [e.g., fibromyalgia, rheumatoid arthritis].
  - Reduce acute post-exercise inflammation to accelerate recovery from physical therapy sessions and prevent further injury.
- **Red Light Therapy:**

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- Promote tissue repair and reduce pain, which is crucial for the patient's recovery from [e.g., muscle strains, tendinopathy].
- Treat specific dermatological conditions such as [e.g., psoriasis, eczema] which are exacerbated by inflammation.

I am prescribing a treatment plan that involves _____ [e.g., 3-5 sessions per week] at this facility for a duration of _____ [e.g., 6 months, 12 months] to achieve the following medical outcomes: _____ [Specify quantifiable goals, such as "reduce body mass index," "improve joint range of motion by X degrees," or "decrease resting heart rate by X bpm"].

I certify that the use of this facility is a core component of the patient's treatment and is not merely for general health maintenance.

Physician's Signature: _____

Physician's Printed Name & Title: _____ [P.T., M.D., D.O., etc.]

NPI Number (National Provider Identifier): _____

Practice Name: _____

Practice Address: _____

Practice Phone Number: _____

Disclaimer

Hydro Air Treadmill Lab, LLC is a membership-based fitness and wellness facility and is not a provider of medical treatment, diagnosis, or advice. The services and equipment provided are for physical fitness, wellness, and recovery purposes. Hydro Air Treadmill Lab, LLC and its employees are not licensed to practice medicine, and the information contained in this letter is based solely on the independent medical judgment of the signing healthcare professional.

Hydro Air Treadmill Lab, LLC is not credentialed with any insurance companies, and we do not bill insurance directly. It is the sole responsibility of the individual member to understand their Health Savings Account (HSA) or Flexible Spending Account (FSA) plan and to confirm eligibility for reimbursement. The individual member is responsible for submitting all necessary documentation, including this Letter of Medical Necessity, to their HSA or FSA administrator for payment or reimbursement.

Hydro Air Treadmill Lab, LLC does not provide financial, legal, or tax advice. The information provided herein is for informational purposes only. It is the responsibility of the member to consult with a qualified financial advisor, attorney, or tax professional to determine the eligibility of their expenses and to ensure compliance with all applicable laws and regulations. Hydro Air Treadmill Lab, LLC shall not be held liable for any decisions made based on the use of this letter or for any issues with HSA/FSA reimbursement.