**Request for Letter of Medical Necessity**

***For Parent to Fill Out:***

Child's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what equipment/service/evaluation do you need this letter?

To whom should the letter go?

How do you feel this equipment/service/evaluation will help your child?

Has anyone else evaluated your child for or recommended your child have this equipment/service/evaluation (e.g., therapist, teacher, medical specialist)? If yes please explain who and when.

Please give any specific features about the equipment/service/evaluation that you feel are critical (e.g., equipment features, special vendors for a service etc.).

Insurance Company Name and Address:

Insured's Name:

Policy #:

Group:

Medicaid #:

***For clinic staff to complete:***

Date last seen at the clinic: