

Letter of Medical Necessity

DATE: _____
To be completed by Physician for _____
Name of applicant
Address _____ phone # _____

Dear Prescribing Physician,
The Foundation for Rehabilitation Equipment and Endowment requests that this Letter of Medical Necessity be completed as soon as possible on behalf of the individual, which you are writing it for. Their application can NOT be processed until our office receives this “Letter of Medical Necessity”.

Medical Diagnosis of Patient: _____

Equipment requested: _____

Do you approve of the request? YES NO (CIRCLE ONE)
Why or why not? _____

If you approve of this request, Please give a detailed explanation for need of this equipment (how will it increase the patient’s independence or improve their functional abilities/quality of life): _____

Signature of Physician: _____ **Phone #** _____
Print name: _____

Please attach a prescription if you approve of the request.
Thank you for your professional guidance and assistance.

Chapter Fax Numbers:
Roanoke 540-777-1030
Lynchburg Fax number: 434-846-3773
Northern Shenandoah Valley 303-593-3519
South Hampton Roads 757-447-6333
Richmond 804-767-4417