



## **Letter of Medical Necessity**

***\*\*To be completed by Medical Professional***

DATE: \_\_\_\_\_

Name of applicant: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

Dear Medical Professional,

The Foundation for Rehabilitation Equipment and Endowment requests that this Letter of Medical Necessity form be completed as soon as possible on behalf of the individual for whom you are writing it. Their application can **NOT** be processed until our office receives this "Letter of Medical Necessity".

Medical diagnosis of patient: \_\_\_\_\_

Equipment being requested: \_\_\_\_\_

Reason for equipment: \_\_\_\_\_

***LEGIBLY PRINT REFERRAL INFORMATION BELOW INCLUDING CREDENTIALS***

Name & Credentials: \_\_\_\_\_

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

Agency: \_\_\_\_\_

Signature: \_\_\_\_\_

Thank you for your professional guidance and assistance.

### **F.R.E.E. Program Fax Numbers:**

Roanoke: 540-777-1030

Lynchburg: 434-846-3773

Northern Shenandoah Valley: 303-593-3519

South Hampton Roads: 757-447-6333

Richmond: 804-767-4417

Williamsburg: 757-337-5032

Harrisonburg: 540-564-5125