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: ____

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Equipment being requested: ______________________________________

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Reason for Equipment: ____

LEGIBLY PRINT REFERRAL INFORMATION BELOW INCLUDING CREDENTIALS

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Name & Credentials: Phone #: ____________________________________

Agency: ____

Signature: ____

Thank you for your professional guidance and assistance.

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