REQUEST FOR LETTER FOR PATIENT OR INSURANCE COMPANY

Date of Request: _____

Patient Name: _____Date of Birth: _____

Physician or Midwife: _____

Type of Letter Needed: _____

Address Letter To:

Name: _____

Address: _____

City, State, Zip: _____

Fax Number (Optional): _____

Does the patient want a copy of the letter (Please Circle)? Yes No

How does patient want letter sent to her?

_____ Fax: Number: _____

_____Send in Mail: Street Address:_____

City, State, Zip: _____

Disability is due to: _____

Date(s) of Disability: _____

Staff Person Recording Information: _____

Other Information: _____

_____

_____

_____

_____

When completed, please provide this form to an administrative staff member.