MEDICAL NECESSITY REQUEST FORM

Applicant Name: _____ Male/Female DOB: _____

Parent/Guardian Names: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Email: _____

Medical Information

Diagnosis: _____

_____

_____

Primary Physician: _____

Insurance Provider: _____

Secondary Insurance: _____

Occupational Therapist (if applicable): _____

Phone: _____ Email: _____

Physical Therapist (if applicable): _____

Phone: _____ Email: _____

Speech Therapist: (if applicable): _____

Phone: _____ Email: _____

By submitting this form, you are waiving any and all claims under HIPPA and release No Bad Days Foundation and Widerman Malek, PL from compliance with HIPPA regulations. All information provided herein will be kept confidential, and used solely to determine grant eligibility.

Equipment Request

Item(s): _____

_____

_____

Provider: _____

Price: _____

Has the equipment request been submitted to insurance for coverage and subsequently denied? Yes [ ] No [ ]

If yes, please provide a letter of medical necessity and the letter of denial from insurance.

Please describe how this equipment will be used to improve the recipient's quality of life: _____

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