



Request for Letter

It is necessary for all fields to be completed before letters will be completed.

Patient Name: _____

Patient Phone Number: _____

Date of Request: _____

Deadline for Letter*: _____

*(Please understand that Providers may require additional time to complete letters and forms.)

Who should the letter be addressed to?

Person or Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Upon completion, will the letter be: MAIL FAX PICK-UP E-MAIL

Please provide the mailing address, fax number or email address to send the completed letter:

Purpose of the Letter:

The Letter should SPECIFICALLY INCLUDE the following information:

There is a fee for letters written by Providers. Payment is required before the letter will be released.

Signature of Patient/ Guardian: _____ Date: _____

Provider or Staff: _____ Date: _____