

Medical Necessity Documentation for the

Vermont Family Network Family Support Fund

Provider’s name: Practice:

Address: Phone: Fax:

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Please describe what is being requested, and why it is medically necessary for this child. The fund can assist with out-of-pocket costs for medications, medical supplies, therapies, specialized equipment, medical travel and more. You can also attach a copy of the prescription instead.**  |
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Provider’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX completed form to Joanne Wechsler @ Vermont Family Network @ **802-876-6291**. Questions: Joanne.Wechsler@vtfn.org