Medical Necessity Documentation for the Vermont Family Network Family Support Fund

Provider's name: _____

Practice: _____

Address: _____

Phone: _____Fax: _____

Child's Name _____ DOB _____

Parent/guardian Name and phone number_____

Diagnosis(es) Related to this request_____

Is this request medically necessary? Yes ☐ No ☐

Medically Necessary Supplemental Funding is requested for:

☐ Medical Supplies
☐ Medical treatment/therapies
☐ Out-of-pocket medication/ supplements
☐ Specialized Equipment
☐ Travel to medical appointments
☐ Other_____

Please tell us why the item or service is medically necessary for this child and how it relates to their diagnosis(es):

Provider's Signature _____

Date _____

Fax completed form to Diane Bugbee at Vermont Family Network at **802-876-6291**.
Questions: Diane.Bugbee@vtfn.org

Please contact the Vermont Family Network and check out vtfn.org for more information about the many types of support we offer families (Education and Coordinated Service Plan support, Parent Match Program, SibShops, etc.)