

MEDICAL VERIFICATION FORM

FORMULARIO DE VERIFICACIÓN MÉDICA



This form is to be completed by a healthcare professional who treats the patient. This form is used to verify a bleeding disorder diagnosis and recommend a durable medical item, piece of equipment, or service that will support prevention, care or treatment for a bleeding disorder.

Este formulario lo debe llenar un profesional de la salud que dé tratamiento al paciente. Este formulario se utiliza para verificar el diagnóstico de trastorno sanguíneo y recomendar un artículo médico no desechable, equipo o servicio que apoyará la prevención, cuidado o tratamiento para un trastorno sanguíneo.

Name of healthcare professional: _____

Name of institution: _____

Type of healthcare professional:

- Physician
- Nurse/Nurse Practitioner
- Hospital Social Worker
- Physical Therapist
- Other (Please Specify) _____

Name of Patient: _____

Patient's Diagnosis: _____

Specific Item/Equipment/Service Requested for Patient (Include Receipts, Invoice, or Link if Applicable):

Please provide a recommendation for the item/equipment/service requested and how it will benefit the patient's bleeding disorder treatment/care:

Please Sign & Date Below.

Healthcare Professional's Signature: _____ Date: _____