MEDICAL VERIFICATION FORM

This form is to be completed by a healthcare professional to verify a bleeding disorder diagnosis and/or recommend a durable medical item/equipment or service that is necessary for the care/treatment of a bleeding disorder.

Name of healthcare professional: _____

Name of institution where healthcare professional is employed: _____

Type of healthcare professional:

- ☐ Physician
- ☐ Nurse/Nurse Practitioner
- ☐ 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:

_____

_____

_____

_____

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_____

Please Sign & Date Below

Healthcare Professional's Signature: _____ Date: _____