Letter of Medical Need
for
Adaptive Equipment/Professional Services

Patient Information

Name: _____

Date of Birth: _____

Services needed from _____to _____ (if applicable)
effective date end date

Check applicable services needed.

Adaptive Equipment☐

List what equipment is being requested:

_____

Professional Services☐

List what professional is being requested:

_____

Medical Reasons/Qualifying Diagnosis: _____

_____

Briefing describe how equipment or services will benefit the health and well-being of the patient: _____

_____

_____ _____
Health Care Provider's name (Printed) **NPI #**

_____ _____
Health Care Provider's Email Address **Phone #**

_____ _____
Health Care Provider's signature **Date**

To email or fax this form, or for any questions, please use Attention to:
Ronelle Baker at AEPS@ou.edu Fax: 405-271-2711, or via phone at: 405-862-6682