Human Services Department

Wyandotte County Developmental
Disabilities Organization

701 North 7th, Rm. 346
Kansas City, KS 66101

Phone: (913) 573-5502
Fax: (913) 573-5511

Letter of Medical Necessity

(This letter will remain in effect for current year only.)

The letter of medical necessity is required with each claim filing and should be completed by the attending physician. Physician will need to specify that treatment is medically necessary for the patient's specific condition which they are being seen for.

Please enter the following information to its entirety (**print clearly**)

Name: _____

Address: _____

Patients DOB: _____

Contact Number: _____

PATIENT MEDICAL INFORMATION

Assistive Device or service needed: _____

Describe the diagnosed condition to be treated:

_____

_____

Describe the recommended treatment:

_____

_____

Is medication approved for over the counter purchase? Yes _____ No _____

Indicate the duration of the treatment:

_____

FOR PHYSICIAN OFFICE USE ONLY

Please Read the following and sign/ date

I agree that the treatment is medically necessary to treat the medical condition above for the specified patient. This treatment is not for general health purposes, to improve the appearances or for cosmetic services.

Physician Signature: _____ Date: _____

Physician Printed Name: _____

Physician's Address: _____