Stat Portable X-Ray
211-18 Union Turnpike
Bayside, NY 11364

Form ID: 03

Please fax signed form to 718-217-5485

Letter Of Medical Necessity

PATIENT INFORMATION

Date

Name (Last, first, middle initial)

Social Security #

Facility Name & Room #

Date Of Birth (MM/DD/YYYY)

This form should be completed by the attending physician to confirm that an examination is necessary to diagnose/treat a specific medical condition.

Please complete the following:

1. Describe the recommended examination requested.
2. Describe the medical condition to be diagnosed.
3. When Was this procedure last performed

   (MM/DD/YYYY)
4. Describe any previous therapy or medications or examinations used to treat above condition.
5. Indicate the duration of recommended treatment and / or medications to treat above condition.

This examination is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health; and is not for cosmetic purposes or to improve appearance.

Signature of Attending Physician

Date (MM/DD/YYYY)

Print Name