

MEDICAID PROGRAM
REQUEST TO PHYSICIAN OR MEDICAL FACILITY FOR MEDICAL DATA

Please return this form by _____

TO: _____

ATTN: _____

Return To: Bureau of Health Services Financing

ATTN: _____

RE: _____
Last First Middle
Address: _____
SSN: _____ Race: _____ Sex: _____ DOB: _____

Please provide the following medical information on the above named person pertaining to:

- Last 24 months
- _____ to present

Please attach copies of any pertinent medical records for the time period specified and test results of continuing significance.

We cannot authorize payment for completion of this form.

1. Is patient under regular medical treatment? Yes No
Date of Next Appointment: _____
2. Current Medical Diagnoses: _____

3. Summary of Medical Data: _____

4. Current Laboratory Data (include dates): _____

A. EKG Report _____
B. Report of Any X-Ray _____
C. Other Pertinent Laboratory Data _____
D. Blood Pressure Readings _____
E. Blood Glucose Levels _____

5. Any Other Medical Findings: _____

6. Is patient on medication? Yes No If **yes**, complete the following.

Name of Medication	Prescription		Dosage	How Often Taken
	Yes	No		

7. Indicate type of work done by patient. _____

Indicate if patient may return to work.

Full Time? Yes No Part Time? Yes No When? _____

Are there any restrictions? Yes No If **yes**, what? _____

What can the patient still do with his impairment? _____

8. Other Comments (please be specific): _____

 Person completing form must sign below.

 Name of Medical Facility

 Physician's Name (Print)

 Hospital Representative / Title (Print)

 Signature of Physician / Date

 Signature of Hospital Representative / Date