LETTER OF MEDICAL NECESSITY

This letter must be submitted on the organization's letterhead. Please, submit with the monthly invoice via the SFTP. Do not email this form, as it contains protected health information.

Date:

Ryan White Program Staff:

I certify that it is a medical necessity for my patient, , to receive

, through local Ryan White Part A funding.

This medication/treatment is necessary to

Sincerely,

Signature of Clinician Date

Printed Name Telephone Number