Place on Medical Provider's Letterhead

Date:

State Council for Persons with Disabilities
Traumatic Brain Injury Fund
Attention: Dee L. Rivard
Margaret M. O'Neill Bldg., Suite 1
410 Federal Street
Dover, DE 19901

Dear Application Review Committee Members:

As a _____, I am writing to confirm that
PCP, MD, DO, PA, NP, PT, OT, SLT, or other licensed medical provider

_____ has a **traumatic brain injury** caused by
Full Legal Name of Patient

_____, which occurred on _____.
Mechanism of Injury Date of Injury

I believe that _____ the following requested service, treatment,
Patient's Name
therapy or equipment recommended below is medically necessary because of the patient's traumatic brain injury:

_____
Requested service, treatment, therapy or equipment

_____

_____

Or I am recommending the following services as beneficial to the patient because of their traumatic brain injury:

_____

_____

I certify that I have submitted a referral for these services to my patient's insurance provider.

Sincerely,

_____
Signature

_____ _____
Name and Title of Treating Medical Provider License Number

Acceptable Medical Providers Include: Applicant's primary care physician (PCP) or other treating licensed medical provider E.g. MD, DO, Physician's Assistant, Nurse Practitioner, Licensed Physical Therapist, Occupational Therapist, or Speech Language Therapist providing treatment for applicant's traumatic brain injury. **Please fax completed form to either: 302-677-7066 or 302-739-1124.**