HEALTH CARE PROVIDERS STATEMENT OF MEDICAL NECESSITY

This statement must be completed and signed by the health care provider employed by _____ where the patient is being treated and has knowledge of the medical necessity for services received by the patient along with knowledge of the patient's medical/mental health.

Patient: _____ **DOB:** _____

Appointment Location: _____

PLEASE COMPLETE ALL THE REQUESTED INFORMATION, IF APPLICABLE (Check appropriate boxes):

☐ This patient is currently under my care at: _____

Please Print: Counselor/Case Manager Name and Phone number

_____

Date of last Assessment: _____ Assessment done by: _____
(Annual assessment review required)

Name of County or Tribe who made the referral and/or is managing this patient:

_____

☐ This patient requires continued medication treatment services.

COMMENTS:

Health Care Provider's signature: _____ Date: _____
Phone Number: _____

Beltrami County Health and Human Services will monitor medication treatment services. Please fax completed and signed statement to MA Transportation @218-333-4131 c/o: Beltrami County Human Services. If you have questions, please call 218-333-8023.