**MEDICARE TRANS**

medicaretransinfo@gmail.com

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: Medical Facilities (clinics, hospitals, physical therapy and pharmacies)

This is to verify that (PATIENT NAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ had

An appointment and was seen in our clinic (APPOINTMENT DATE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At (clinic, hospital, physical therapy, pharmacy, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor or Hospital personnel signature