Physician's Certification of Medical Condition

Items marked with (*) are required to process an application

Parent/Legal Guardian: After your child's physician has completed this form, please attach it to your child's online application. You may do this by scanning a copy to your computer, or by taking a picture of each page of the form and attaching them.

All fields must be completed by the child's physician

Child's Medical Information

NOTE: Physician completing and signing this document must be an M.D. or D.O. For hearing-related conditions it can be completed and signed by an Au.D (audiologist).

The parent/legal guardian of the child listed above has applied for a medical grant with the UnitedHealthcare Children's Foundation (UHCCF). Please complete the following medical information.

*Child's Name _____

*Child's Date of Birth _____

*Child's Primary Diagnosis _____

Child's Secondary Diagnosis (if applicable) _____

*How are the current diagnoses impacting the child's life?

- ☐ Medically
- ☐ Socially
- ☐ Psychologically/Behaviorally

*Grant Services

I recommend the following services to be considered for the grant (up to 5 recommended services permitted on the application) Please be specific. Example services: Dr/Specialist Visits, ER/Urgent Care, Inpatient/Out-Patient stays, Medical Drugs, Procedures/Treatments, Imaging/Testing, Labs, Medical Equipment and supplies, DME, Orthotics, Therapies- PT, OT, Speech, ABA, Mental Health, etc.

Service 1 _____

Service 2 _____

Service 3 _____

Service 4 _____

Service 5_____

*Goal of these therapies/treatments is _____

_____

_____

Additional notes or comments _____

_____

Physician Information

*Physician Name _____

*Title

- ☐ M.D.
- ☐ D.O.
- ☐ Au.D

Provider I.D. # _____

Address and Phone Number _____

_____

_____

*Physician Signature _____

*Date _____

Physician: Thank you for taking time to complete this information. Please return this form back to the child's parent and/or legal guardian so that they may attach it to their child's grant application.