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**PATIENT REQUEST FOR LETTER OR FORM TO BE COMPLETED BY VITAL HEALTH INSTITUTE**

PATIENT INFORMATION (Please Print):

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Last 4 Digits of SSN: \_\_\_\_\_

Date the form needs to be completed: \_\_\_\_\_

**Please allow 2 weeks for processing, Rush requests will incur additional processing fees of \$25.00 – Please "RUSH" my letter or form \_\_\_\_\_ (initial)**

Type of Letter or Form requested:

**Letters are \$50.00 for a single page and \$75.00 for anything longer – (FYI - Due to schedules; letters may be completed by either the Nurse Pract. or Dr. Cook)**

**Forms are \$10.00 for a single page and \$20.00 for anything longer**

- Prior Authorization Letter
- Employer Letter
- Disability Letter
- School Letter
- Insurance Letter
- Other \_\_\_\_\_

- FMLA Form
- Disability Form
- Disability Extension Form
- Insurance Form
- Other \_\_\_\_\_

I request that the Letter / Form be addressed to»»

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Notes: \_\_\_\_\_

I request that when the Letter / Form is completed that it be sent to: \_\_\_\_\_

Via:  Patient will pick up  Fax  EMAIL  Mail (patient responsible for postage)

**I am aware of the costs associated with this request and will provide my credit card # to cover charges which VHI will charge upon receipt of this Request.**

Credit Card#: \_\_\_\_\_ Exp: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

CV Code: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Card Holder Name: \_\_\_\_\_ Card Holder Tel# \_\_\_\_\_

**For Internal Use Only:**

Date VHI received request: _____	Initial Date of Tx: _____
Confirmed Rush Fees with Pt?: _____	SX Date: _____
Cost: \$ _____	Start Date: _____
	RTW Date: _____