Provider Verification Form

To be completed by the Licensed Physical Therapist

To the Provider: The family of a patient in your care is applying for a medical assistance grant through the **Buckaroo Foundation**. Our mission is to improve access to therapy for Baldwin County residents. To process this application, our Bylaws require specific clinical and financial documentation.

1. Patient & Provider Information

- **Patient Name: _____**
- **Clinic/Facility Name: _____**
- **Tax ID (EIN): _____**
- **Mailing Address for Payment: _____**

- **Phone Number: _____**

2. Clinical Confirmation

- **Type of Therapy:** Physical Therapy (PT)
- **Is this therapy medically necessary for the patient?** [ ] Yes [ ] No
- **Primary Diagnosis: _____**

3. Required Attachments

Please provide the following to the parent/guardian to include in their application:

- [ ] **Current Invoice:** A breakdown of costs for the sessions to be covered by this grant.
- [ ] **Therapeutic Notes:** A copy of the most recent clinical notes detailing the patient's progress or treatment plan.

4. Provider Acknowledgment

I confirm that the patient listed above is receiving Physical Therapy services at this facility. I understand that if a grant is awarded, the Buckaroo Foundation will issue payment **directly to this clinic** via the mailing address provided above.

Therapist Name (Printed): _____

Therapist Signature: _____ Date: _____

Submission Instructions for Families:

Please include this completed form along with your **Full Application Packet** and mail it to:
Buckaroo Foundation, Inc. 30941 Mills Lane, Suite G-336 Spanish Fort, AL 36527