Alternative Therapy Endorsement Request

Patient Information

Full Name

Patient ID / MRN

Date of Birth

Contact Information

Requested Alternative Therapy

Type of Therapy

Therapy Description

Proposed Provider

Duration / Frequency

Reason for Request

Clinical Justification

Previous / Standard Therapies Attempted

Requesting Clinician

Name

Clinician ID

Role / Specialty

Contact Information

Date of Request

Supporting Documents

List file names / references (if any)