

Vermont Medication Assistance Program (VMAP) Physician Verification Form

This form is to be completed and signed by a medical provider for individuals applying for the Vermont Medication Assistance Program through the Vermont Department of Health

Patient Name: _____

Last 4 digits of Patient's SSN: XXX-XX-__ - __ - __ - __

Patient's DOB (mm/dd/yyyy): __ / __ / _____

Name of Medical Provider: _____

Telephone Number of Medical Provider: (____) - ____ - _____

Patient's Medical Status: Positive Negative

CD4 Count: _____ Draw Date: __ / __ / _____

Viral Load: _____ Draw Date: __ / __ / _____

Signature of Medical Provider

__ / __ / _____
Date

Please return this form with the completed application to:

VMAP Coordinator
Vermont Department of Health
PO Box 70- Drawer 41 IDEPI
Burlington, VT. 05402
P: (802) 951-4005
F: (802) 863-7314