

Medical Report Application for Disability Benefits

Date: [Insert Date]

Your Name: [Insert Your Name]

Your Address: [Insert Your Address]

Your City, State, ZIP Code: [Insert City, State, ZIP Code]

Email: [Insert Your Email]

Phone Number: [Insert Your Phone Number]

To:

Medical Provider's Name: [Insert Provider's Name]

Clinic/Hospital Name: [Insert Clinic/Hospital Name]

Address: [Insert Clinic/Hospital Address]

City, State, ZIP Code: [Insert City, State, ZIP Code]

Subject:

Request for Medical Report for Disability Benefits Application

Dear [Medical Provider's Name],

I am writing to formally request a detailed medical report regarding my health condition, which has affected my ability to maintain employment. This report is necessary for my application for disability benefits.

The specific information needed includes:

- Diagnosis and prognosis of my condition.
- Treatment history and any ongoing treatments.
- Full description of how my condition impacts my daily functionality.
- Any pertinent medical records or test results.

I appreciate your prompt attention to this matter, as it is crucial for the timely submission of my disability benefits application. Please feel free to contact me at [Insert Your Phone Number] or [Insert Your Email] should you require further information.

Thank you for your assistance.

Sincerely,

[Your Name]