TOP AID
HEALTHCARE, INC

Top Aid Healthcare, INC

69 Park Ave Worcester Ma. 01608

Phone: 508-343-8555 Fax:508-519-0353

Provider Name:_____ Date_____ DOB

_____ Client Name_____

Dear Physician,

The above-named patient has applied for AFC services at a minimum we will need the treating physician to submit the information requested below for MassHealth Clinical Eligibility,

The Physician Summary Form (PSF) must be completed by a MD, NP, PA and returned to Top Aid Healthcare with the following information.

1. **Date of last Physical examination (Must be within one year)**
2. **Date of last office visit Face to Face (Must be within the last 3 months)**
3. **Diagnoses (List can be attached)**
4. **Medication List (List can be attached)**
5. **Please send a copy of the last History & Physical Notes**
6. **Physician's Signature**
7. **Allergies List**

Once the form has been completed, and all paperwork has been attached please **Fax** to **508-519-0353**, Top Aid Healthcare, INC. Thank you for your time.

Sincerely,

Josephine Putu

Program Manager
Top Aid Healthcare, INC
AFC Program