Beth Israel Lahey Health
Lahey Hospital & Medical Center

# DERMATOLOGY PROVIDER ATTESTATION

**Patient Name:** _____

**Patient DOB:** _____

**I, _____am a dermatology provider at**
**(First and last name of MD, NP, PA)**

_____

_____
**(Name and location of practice)**

**And hereby attest that the above-named patient has one of the following diagnoses (please check the appropriate box):**

- ☐ **A clinical diagnosis OR biopsy-proven scarring alopecia (LPP, FFA, CCCA, other)**
  **→PLEASE LIST SCARRING ALOPECIA DIAGNOSIS HERE:**
  _____
- ☐ **Moderate to severe alopecia areata, affecting 30% or more of the scalp**
- ☐ **Chemotherapy or cancer therapy induced alopecia**
- ☐ **Alopecia due to graft versus host disease (GVHD)**

**SIGNATURE OF MEDICAL PRACTITIONER:** _____

**PRACTICE PHONE NUMBER for questions:** _____

Hair Loss Center of Excellence - Lahey Hospital & Medical Center, Burlington & Peabody

**PLEASE FAX THIS COMPLETED FORM TO 617-303-8151**
**ATTN: KIM SOLDANO**

**THANK YOU!**