Certification of Medical Necessity Form

Welfare Fund - Health Reimbursement Arrangement

PLUMBERS LOCAL UNION No.1 WELFARE FUND

50-02 5th Street, Long Island City, New York 11101 Tel. (718) 835-2700

| (i) Seed Security Number (ii) Seed Security Number (iii) Seed Security Number (iii) Seed Security Number (iii) Carrett of Least Employer (iiii) Retired (iiii) Current or Least Employer (iiii) Least (iiii) Current or Least Employer (iiii) Least (iiii) Current or Least Employer (iiii) Least (iiii) Least (iiii) Current or Least Employer (iiii) Least (iiiii) Least (iiii) Least (iiiii) Least (iiiiii) Least (iiiii) Least (iiiii) Least (iiiiii) Least (iiiiiii) Least (iiiiiiii) Least (iiiiiii) Least (iiiiiii) Least (iiiiiii) Least (iiiiiii) Least (iiiiiiii) Least (iiiiiiii) Least (iiiiiiii) Least (iiiiiiiii) Least (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii | (A) Member Information | | Use a ballpoint pen i | to complete form | |
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| (c) Provider Certification: To be completed by the Provider This diagnoses and or treatment is medically necessary to treat the medical condition as described above. The diagnose or treatment is not for general health or cosmetic purposes. Provider Signature Provider Signature Provider Signature Provider Signature: Date To be completed by the Provider (a) First (b) First (c) First (c) First (c) First (d) Inst (d) Inst (e) Date (e) Date (f) Last date of Employment (f) Last date of Employment (g) Inst | (1) Social Security Number | (2) Last | | | |
| (12) Resided (14) Auditor (15) Current or Last Employer (15) Resided (14) Auditor (15) Current or Last Employer (16) Patient Information (B) Patient Information Patient's Name (1) Last (2) First (3) Inst. (3) Inst. (C) Provider Certification: (C) Provider Certification: To be completed by the Provider (3) Inst. (C) Provider Certification: (C) Provider Certification: (D) Example (1) Last (2) First (3) Inst. (E) Provider Certification: (C) Provider Certification: (D) Example (1) Last (2) First (3) Inst. (E) Provider Name (Please print) (D) Last (2) First (3) Inst. (E) First (3) Inst. (E) Provider Signature (E) Last (3) Inst. (E) First (3) Inst. (E) Provider Signature (E) Last (3) Inst. (E) First (4) Inst. (E) First (5) Inst. (E) F | (5) Street | (6) City | (7) State | (8) Zip | |
| (13) Residual (14) Active (15) Current or Last Employer (15) Last | , , | (10) Sex M F | (11) Home Phone Number / Cell Number | | |
| (C) Provider Certification: To be completed by the Provider Medical Condition Information Patient's Name (1) Last (2) First (3) Init. Medical Condition Recommended treatment/services/product Please describe how the diagnose/treatment/service/product impacts the medical condition: (C) Provider Certification: To be completed by the Provider This diagnoses and or treatment is medically necessary to treat the medical condition as described above. The diagnose or treatment is not for general health or cosmetic purposes. Provider Name (Please print) (1) Last (2) First (3) Init. Provider Signature I certify that I am the current treating physician and that the prescribed treatment on this form is medically necessary for treating the patient's condition. Any statement on my letterhead attached here to, has been reviewed and signed by me. I understand that any falsification, omission, or concealment of medical fact may subject me to civil or criminal liability. (D) Participant Certification: To be completed by the Participant Paticipant Signature: Date: I certify that the services indicated above are medically necessary (that is, required for the prevention or alleviation of a physical or mental defect or illness). I understand that I must submit a completed copy of this Certification of Medical Necessity form or a provider letter containing the same information with each request for reimbursement of this | | | /16) Last date of Employment | - | |
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