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

(A) Member Information

Use a ballpoint pen to complete form

(1) Social Security Number ____ (2) Last ____ (3) First ____ (4) Init. ____

(5) Street ____ (6) City ____ (7) State ____ (8) Zip ____

(9) Date of Birth ____ (10) Sex M ☐ F ☐ (11) Home Phone Number / Cell Number ____

(12) E-mail Address ____

(13) Retired ☐ (14) Active ☐ (15) Current or Last Employer ____ (16) Last date of Employment ____

(B) Patient Information

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)* ____ Date ____
(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

Participant 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 expense.

NOTE: PLEASE MAKE A COPY OF THE FORM FOR YOUR PERSONAL RECORDS.