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) 223-4313 6/2025

(A) Member Information

Use a ballpoint pen to complete form

(1) Social Security Number [redacted] (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

To be completed by the Provider

This diagnosis 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.

PHYSICIAN STAMP HERE
(required)

(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.