

## MEDICAL NECESSITY FORM

Patient Name: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Participant SSN: \_\_\_\_\_

Participant's Employer: \_\_\_\_\_

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition. Complete the following:

1. Describe the diagnosed medical condition being treated. (Include diagnosis code.)

\_\_\_\_\_

2. Describe the recommended treatment.

\_\_\_\_\_

3. Indicate the duration of treatment.

\_\_\_\_\_

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health; and is not for cosmetic purposes to improve appearance.

Signature of Attending Physician: \_\_\_\_\_

Printed Name of Attending Physician: \_\_\_\_\_

Address of Attending Physician: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number of Attending Physician: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_