Medical Necessity Certification Form

USAdmin Services, LLC (Febco Division)

Participant Information

Employer Name: _____

Employee Name: _____

Social Security Number:_____Birthday: _____

Patient Information *(to be completed by a licensed healthcare provider)*

Patient Name: _____

Social Security #:_____Birthdate: _____

Diagnosis:_____

Recommended Treatment: _____

_____

_____

How will this treatment correct the symptoms or diagnosis? _____

_____

How long is the treatment required? _____

_____

Provider Name: (Please Print) _____

Provider Address:

_____

Provider Telephone #: _____

*Provider Signature:_____Date: _____

*** By signing this form, you agree that this treatment is required and medically necessary (and not for general health purposes or for cosmetic reasons).**

Signature *(Incomplete forms will not be processed)*

Employee Signature:_____Date: _____

Fax this form to: (502) 695-9692 or (423) 634-0625

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