

Medical Necessity Certification



According to the IRS rules and regulations that govern your benefits program, some medical products and services are only eligible to be reimbursed when your doctor or health care provider deems them medically necessary. The provider must indicate your (or your spouse or dependents) medical diagnosis, what treatment is needed, and how this treatment might alleviate your medical condition. This certification will assist our participants and their doctors in providing exactly what we need to process your claim.

Employer: _____
Employee Name: _____
Social Security #: _____

Patient Name: _____
Social Security #: _____ Birthdate: _____

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

Diagnosis: _____
Recommended Treatment: _____

How will this treatment correct the symptoms or diagnosis? _____

How long is the treatment required? _____

Provider Name: _____

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).*

Employee Signature: _____ Date: _____

If you have questions, feel free to call **Febco, Inc.** toll-free 1-800-489-1539.

Customer Service is available to assist you, Monday through Friday, 8:00 A.M. until 4:30 P.M., Eastern Time.

Please fax this form to: 502-695-9692