Medical Necessity Certification Form

Febco Benefits Administration

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

Febco Benefits Administration
PO Box 5010
Frankfort, KY 40602