

Medical Determination Form

Patient Name:

Patient's Employer:

Patient's Social Security Number:

This form should be completed by the attending physician to confirm treatment is necessary to treat a specific medical condition or disease. The form may be used for specific treatments and dual purpose to reimburse healthcare expenses. PLEASE NOTE THAT THIS FORM MUST ACCOMPANY THE RECEIPT. THE COMPLETION OF THIS FORM BY A DOCTOR DOES NOT GUARANTEE REIMBURSEMENT.

1. Describe the diagnosed medical condition or disease that requires treatment.
2. Describe the recommended treatment.
3. Indicate the length of the treatment.

This treatment is medically necessary to treat the specific medical condition or disease described above. This treatment is in no way for general health and is not for cosmetic purposes.

Physician's Signature

Print Name

Phone Number

Date

Physician's Address

City

State

Zip