AMERICAN BENEFITS GROUP

CERTIFICATION OF MEDICAL NECESSITY FORM

Please fill in your information below and have your physician complete the lower section of this form in order to certify the medical necessity of the product or service you are claiming.

Patient's Name: _____

Participant's Name: _____

Participant's Employer: _____

Participant's Last Four Digits of SSN: _____

Physician Please Complete This Section

Description of Medical Condition: _____

_____

_____

Description of recommended treatment: _____

_____

Recommended duration of the treatment: _____

_____

I certify that the product or service that I have recommended is medically necessary to treat the patient's specific medical condition indicated above and is not solely for the general health of the patient or for cosmetic purposes:

Physician's Signature: _____ Date: _____

Printed Name of Physician: _____

Fax Toll Free: 877-723-0147 or email to claims@amben.com

(No Fax Machine? Mail to: American Benefits Group, P.O. Box 1209, Northampton, MA 01061-1209)