

# Certificate of Medical Necessity

## Michelle's Law - UPMC Health Plan

### This section must be completed by the subscriber.

Subscriber name:

Subscriber ID #:

Name of employer group:

Group #:

Dependent name:

Dependent ID #:

Dependent date of birth: / /

Name of institution of higher education

Current full-time student\*: Yes No

Date (12 month) medical leave begins: / / / OR

Date part-time student status begins: / / /

Expected date of return to full-time student status: / / /

*\* Attach verification of full-time student status from institution of higher education*

### This section must be completed by the physician's office.

Physician name:

Address:

Office phone: Office fax:

Date of dependent's last office visit: / / /

Dependent's medical diagnosis and ICD 9 code:

Estimated length of treatment for medical condition

Dependent has been diagnosed with a serious illness or injury for which a leave of absence or other change in enrollment is medically necessary. Yes No

Please attach any reports, such as testing, OR reports, and physician progress notes relevant to determining medical necessity.

### For UPMC Health Plan Internal Use Only

Senior Medical Director Signature: Date: / / /

Approved: Yes No

Comments:

**MAIL TO:** Attention: Enrollment Services or **FAX TO:** 412-454-5936

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# UPMC HEALTH PLAN

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