UNITED STEELWORKERS
USW
UNITY AND STRENGTH FOR WORKERS

Mail Forms to:
Steelworkers Health and Welfare Fund
60 Blvd of the Allies, Suite 700
Pittsburgh, PA 15222
Fax to: 412-562-2276
Email to: arcelormittalhai@gmail.com

ArcelorMittal

# VERIFICATION FORM FOR THE 2018 USW-ARCELORMITTAL HEALTH AWARENESS INITIATIVE

Form to be filled out by your healthcare provider to verify that you or your spouse, if applicable, completed the Wellness Examination **from 10/1/17 – 9/30/18**. Separate forms are required for you and your spouse, if applicable. The Date of Service (DOS) indicated by the healthcare provider will be verified against the Highmark claims history.

## *Section 1: Completed by Employee, Retiree or Surviving Spouse*

Check One: ☐ Active Employee ☐ Non-Medicare Retiree, Medicare Retiree for Non-Medicare Spouse, or Surviving Spouse

***Employee/:*** _____

***Retiree*** Last Name First Name M.I. Date of Birth (mm/dd/yyyy)

**Email:** _____ **Phone #** (___) _____

**Insurance Card ID#** (Numeric Portion Only) ☐☐☐☐☐☐☐☐☐☐☐☐

**Home Address:** _____

Street City State Zip

**Verification is for:** ☐ Employee, Retiree or Surviving Spouse ☐ Spouse covered through my ArcelorMittal Healthcare Plan

**If Verification Form is for your Spouse**, complete:

*Spouse:* _____

Last Name First Name M.I. Date of Birth (mm/dd/yyyy)

_____ _____

**Employee/Retiree Signature** **Date**

_____ _____

**Spouse Signature (only if spouse verification)** **Date**

**If the spouse has primary coverage through their employer and the claim is not filed through Highmark, attach an Explanation of Benefits (EOB) for the date of service from the primary insurance**

## *Section 2: Completed by Healthcare Provider**

**Date of Service** _____

The above named patient was seen in my office on the date of service listed. I completed the examinations check marked below.

**(Do not provide examination results.)**

**Check the box if completed on Date of Service**

***Height*** ☐

***Weight*** ☐

***Blood Pressure*** ☐

***Discussion of appropriate recommended exams, screenings and procedures*** ☐

***Provider is not liable if patient does not follow recommendations.***

**Healthcare Provider Name** _____ **Phone #** _____

**Healthcare Provider Signature** _____

**Date Signed** _____ *If you have an office stamp, please apply here:*

***Attention Provider**

***Work Physicals*: A Work Physical does not qualify as a wellness exam.**

***Preventive testing*: When ordering preventive testing for your patient, please refer to the Highmark BCBS Preventative Schedule for covered testing when tests are ordered and coded as preventive/screening. Tests not included within this schedule will not be covered without a diagnosis code other than "routine", and patient could be responsible for the entire charge. Tests ordered and coded for diagnostic purposes will be processed under the diagnostic benefit, and medical policy guidelines will be used in determining benefit and payment.**