

Tufts Health Plan Physician Certification Form

This form may be used to certify medical necessity for Michelle's Law coverage eligibility. Michelle's Law provides for continued health plan coverage for a student dependent who experiences a medically necessary leave of absence and would otherwise no longer be eligible for coverage.

Please complete the following:

1. Subscriber Name: _____ ID Number: _____
2. Home Address: _____
3. City: _____ State: _____ Zip Code: _____
4. Dependent's Name: _____ Birth Date ___/___/___
5. Dependent's Relationship to Subscriber: _____
6. Dependent's Address: _____
7. City: _____ State: _____ Zip Code: _____
8. Please describe the serious illness / injury: _____

9. In your professional opinion, is the dependent described above suffering from a serious illness or injury which necessitates a medically necessary leave of absence from, or change in enrollment at a post secondary educational institution?

Yes: _____ No: _____

If yes, please indicate the date the leave started: ___/___/___ and the anticipated date the leave ends ___/___/___.

Attestation:

This document has been completed by (print name) _____, the dependent's doctor or treating provider and is accurate to the best of his/her ability.

Name of Treating Provider: _____
Provider Specialty: _____
Office Address: _____ City: _____ State: _____ Zip Code: _____
Office Telephone Number: _____ Office Fax Number: _____

Provider Signature: _____ Date: _____