



Wellmark Blue Cross Blue Shield of Iowa
Wellmark Blue Cross Blue Shield of South Dakota

MEDICAL NECESSITY FORM

Patient Name: _____

Relationship to Participant: _____

Participant Name: _____

Participant SSN: _____

Participant's Employer: _____

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition. Complete the following:

1. Describe the diagnosed medical condition being treated. (Include diagnosis code.)

2. Describe the recommended treatment.

3. Indicate the duration of treatment.

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health; and is not for cosmetic purposes to improve appearance.

Signature of Attending Physician: _____

Printed Name of Attending Physician: _____

Address of Attending Physician: _____

Phone Number of Attending Physician: _____

Date: ____/____/____