



MEDICAL DETERMINATION FORM

Patient Name: _____
Participant Name: _____
Participant's Employer: _____
Participant SSN: _____
Daytime Phone Number: _____

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

1. Describe the diagnosed medical condition being treated. (Include diagnosis and ICD codes.)

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 or relieve stress.

Attending Physician Signature Date

PLEASE PRINT:

Physician Name:	_____
Address:	_____
Telephone:	_____

Mail or fax completed form to: Stanley, Hunt, DuPree & Rhine, Inc.
SHDR Flexible Reimbursement
PO Box 6400
Greenville, SC 29606

FAX: 1-252-293-9048 or 1-252-293-9049