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 indicated by the healthcare provider will be verified.

## *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**

## *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 <u>not</u> provide examination results**.)

**<u>Check the box if completed on Date of Service</u>**

***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:*