UNITED STEELWORKERS
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 2017 USW-ARCELORMITTAL HEALTH AWARENESS INITIATIVE

USE THIS FORM IF **HIGHMARK** ADMINISTERS YOUR MEDICAL INSURANCE IN 2017.

Form to be filled out by your healthcare provider to verify that you or your spouse, if applicable, completed the Wellness Examination from 10/1/16 – 9/30/17. Separate forms are required for you and your spouse, if applicable.

Section 1: Completed by Employee/Non-Medicare Retiree or Surviving Spouse

Check One: ☐ Active Employee ☐ Non-Medicare Retiree or Surviving Sposue

*Employee/Retiree:*_____

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

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

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

Address: _____

Street City State Zip

Verification is for: ☐ Employee/Retiree or Surviving Spouse ☐ Spouse covered under 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 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:*

USE THIS FORM IF **HIGHMARK** ✓ADMINISTERS YOUR MEDICAL INSURANCE IN 2017.