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 (Please retain your Fax confirmation)
Email to: ccliffshai@gmail.com

CLIFFS

VERIFICATION FORM FOR THE 2021 USW/CLEVELAND-CLIFFS 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 01/01/2021 – 09/30/2021.** Separate forms are required for you and your spouse, if applicable.
- **In order to meet the 2021 Health Awareness Initiative requirement:**
  (1) It is mandatory that you and your spouse, if applicable, submit the completed official USW/Cleveland-Cliffs Health Awareness Initiative verification form, and
  (2) The completed form must be submitted by 11/15/2021.

Please confirm who this form applies to. Separate forms must be completed for both you and your spouse, if applicable.
This form is for: ☐ **Myself** (Employee, Retiree or Surviving Spouse) ☐ **My Spouse** covered through my Cleveland-Cliffs Healthcare Plan

Section 1: Completed by Employee, Retiree or Surviving Spouse

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

Name: _____
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

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 (All boxes must be checked)

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:*

***Attention Provider**

***Work Physicals*: A Work Physical does not qualify as a wellness exam.**

***Preventive testing*: When ordering preventive testing for your patient, please refer to the Highmark BCBS Preventative Schedule for covered testing when tests are ordered and coded as preventive/screening. Tests not included within this schedule will not be covered without a diagnosis code other than "routine", and patient could be responsible for the entire charge. Tests ordered and coded for diagnostic purposes will be processed under the diagnostic benefit, and medical policy guidelines will be used in determining benefit and payment.**

Form revised 01/14/2021