LMHF™ Wellness

Labor-Management Healthcare Fund is the administrator of health, prescription, and dental coverage. It is our goal to help ensure your overall satisfaction with our program, plans of benefits offered, performance of insurance carriers, as well as all customer service conduct.

Preventative Screening Verification

I hereby confirm that I am the Physician for _____,
(Please Print Patient Name)

BlueCross BlueShield Member Identification Number, _____. This patient presented at my office on _____, and was provided with the following preventative care screening (please circle one):
(Month) (Day) (Year)

Colonoscopy

Annual Mammogram

Annual Gynecological

Annual Eye Examination

Annual Prostate

Annual Dental Examination

Cancer

(Other) – Please Define _____

A SEPARATE FORM (SIGNED & DATED BY YOUR PHYSICIAN) IS REQUIRED FOR EACH SCREENING

Physician Signature: _____

Printed Name: _____

Date Signed: _____

Faxed Copies Not Accepted

Copies can be made of this document. However, ORIGINAL signature is required. Additional forms are available on LMHF website or by calling LMHF Office.

3786 Broadway Street
Cheektowaga, NY 14227
Phone (716) 601-7980 ❖ Fax (716) 601-7984
www.LMHF.net