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 Healthcare Provider for _____,
(Please Print Patient Name)

BlueCross BlueShield Member Identification Number, _____. This patient presented at

on _____, and was provided with the following preventative care
(Month) (Day) (Year)

screening (please circle one): (One form per screening)

Colonoscopy

Annual Gynecological Examination

Annual Prostate Examination

Annual Dermatology Examination

Vaccinations - Please Specify
Influenza, Pneumonia or other (Attach form) _____
Other Screening - Please Specify (Attach form) _____

Annual Mammogram

Annual Eye Examination

Annual Dental Examination

Annual Cancer Screening

A SEPARATE FORM (SIGNED & DATED BY THE PROVIDER) IS REQUIRED FOR EACH SCREENING

Provider Signature: _____ Date:_____

Printed Name & Title: _____

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.

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