



PHYSICIAN CERTIFICATION FOR H1N1 ANTI-VIRAL REIMBURSEMENT PROGRAM

Physician Name: _____ Patient Name: _____

Office Phone#: _____ Patient Date of Birth: _____

Office Fax#: _____ Member SS#: _____

Patient Phone#: _____

Please indicate patient's high-risk status:

- Hospitalized for H1N1 infection
- Age 5 or younger
- Age 65 or older
- Immunocompromised – Diagnosis _____
- Chronic Disorder: pulmonary; cardiovascular (except hypertension); metabolic (including diabetes); renal; hematologist; neurologic or neuromuscular - Diagnosis _____
- Pregnant Women

Medication prescribed (name, strength, dosage): _____

Please indicate if prescribed for treatment of:

- (1) a patient infected with the H1N1 virus
- (2) close contact exposure prophylaxis

If (2) is selected, please describe contact _____

Any additional pertinent information: _____

Physician's Signature: _____ Date _____

This Form should be completed by the physician and returned to the patient/member. The member should mail this form, along with the pharmacy receipt for anti-viral medication, for review for possible reimbursement to:

Dr. James Sidel, Medical Director
TeamstersCare
16 Sever Street
Charlestown, MA 02129
617-241-9220