



Wig (Hair Piece) Physician Certification Form

Participant: _____ **SSN:** _____

Patient: _____ **Date:** _____

Active and Retired Participants and their eligible dependents enrolled in the MPIHP/Blue Shield Plan who have undergone chemotherapy, radiation therapy to the head or another medical condition of the scalp, are eligible for reimbursement for one wig/hair piece costing up to \$240 per lifetime, upon submission of a physician-executed certification form attesting to the fact that the prescribed wig is essential to the patient’s mental health, a patient-completed claim form, and the receipt for the wig/hair piece, to the West Coast Plan Office.

Further, provided the circumstances noted above are still applicable, if the eligible dependent is age 16 or under, the Plan will recognize wigs/hair pieces as eligible for reimbursement for two (2) wigs, up to \$240 per wig/hair piece, \$480 per lifetime.

Physician Certification

Diagnosis: _____

Clinical Summary (Please refer to any mental or psychological necessity) _____

Physician’s Name: _____ **License #** _____

Address: _____

Telephone: _____ **FAX** _____

Physician’s Signature

Date