MOHS' CERTIFICATION STATEMENT

Please complete the following for all Mohs' procedures and submit:

- with claims for Mohs' procedures; or
- fax completed form to: (866) 634-8917

If you need assistance, please call: (800) 811-4793

CERTIFICATION STATEMENT

I, the undersigned healthcare provider, am an approved participating member of the HealthOne Alliance, LLC Network of Participating Providers ("Network"). I satisfy the eligibility criteria and have been approved by the Network credentialing process. I hereby certify that I have personally performed the services that are identified on the claims submitted on__________________(date) for the patient(s) and that the services were medically necessary based upon my personal evaluation of each patient's symptoms, clinical testing and establishing a treatment plan for the patient. The patient has been evaluated in accordance with industry and professional standards of the medical profession and the services rendered reflect the industry standard recommended treatment plan for patients with like and similar circumstances.

PATIENT INFORMATION

Patient Name: ____

Patient Alliant ID: ____

PROVIDER INFORMATION

Physician Signature: (no stamps accepted) ____

Physician Name: (please print) ____

Date: __________________