IMMEDIATE FAMILY MEMBER TREATMENT CERTIFICATION FORM

This form is to be used when MotivHealth has reason to believe that a provider performed healthcare services to an immediate family member and charged MotivHealth for those services. You may use this form to certify that the treatment you received from a provider was not performed by an immediate family member.[1] Providers who are immediate family members are prohibited from billing for healthcare services that are provided to immediate family members. If MotivHealth discovers that a member has mislead or provided false information regarding the relationship between their provider and themselves, the member will be responsible to pay for their own medical claims and may have their policy terminated with MotivHealth.

If you need help completing the form, please contact our Personal Health Assistants (PHAs) at 844-234-4472 or PHA@motivhealth.com.

When completed and signed please mail to:

MotivHealth Insurance Company
P.O. Box 7009718
Sandy, UT 84070

You may also email this form to PHA@motivhealth.com or fax this form to: 844-533-1289.

Section I. Member Information			
Name of Member:	Group ID #:	Member ID #:	
Social Security Number:	Date of Birth (mm/dd/yyyy):		
Address:	City:	State:	Zip Code:
Telephone Number:			

Section II. Please provide details about the relationship between the member and provider.

[1] *See* R590-277-4(iv)(nn) for definition of Immediate Family Member.

Section III. Signature - This document must be signed by the member or the member's personal representative.	
I certify that the member was not treated by an immediate family member at any time that they have had a policy with MotivHealth. I certify, under penalty of perjury, that the suspected provider is not an immediate family member. I understand that I can only sign on behalf of a minor child under the age of eighteen (18).	
Signature:	Date: (mm/dd/yy)

Section IV. If Section III is signed by a Personal Representative, please complete the information below.	
If you are signing as a power of attorney, legal guardian, executor, or administrator, please attach a copy of the legal documents.	
Personal Representative's Name:	Relationship to Member:
Personal Representative's Address:	City:
Personal Representative's Phone Number:	Representative's Email:

Any changes to the form must be approved by the privacy officer: Compliance@motivhealth.com.