Statement on the Collection and Use of Social Security Numbers

Human Resources

In accordance with the requirements of Florida law (Section 119.071, Florida Statutes), the University of West Florida collects social security numbers only if specifically authorized or required by law or if imperative for the performance of the University's duties and responsibilities. The University may collect social security numbers for some or all of the following purposes: identity tracking and management; billing and payments; credit worthiness; data collection; reconciliation and tracking; benefit processing; tax and scholarship reporting; financial aid processing; student health services, and reporting to authorized state and federal government agencies. Federal and state laws require us to protect social security numbers from disclosure to unauthorized parties. Students and employees are assigned UWF identification numbers to assist in tracking and protecting their personal information.

UWF Forms	Form Purpose	Purpose for SSN#	Statutory Authority	Mandated, Authorized or Business Imperative
FRS Certification Form	Eligibility to be employed	Applicant Identification	Section 119.071(5)(a)6.g, F.S.	Mandated
Level II Background Screening Request Form	Eligibility to be employed in a position of special trust	Applicant/employee identification	Section 119.071(4)(a)2.b., F. S.	Mandated
Verification of Employment Authorization Release	Employment verification	Employee identification	Section 119.071(5)(a)(2)(a)(II), F.S.	Business Imperative
Third Party Non-UWF Forms	**Purpose**	**Purpose of SSN#**	**Statutory Authority**	**Mandated, Authorized or Business Imperative**
Form I-9, Employment Eligibility Verification (US Department of Homeland Security)	Verify each new employee (both citizen and noncitizen) hired after Nov 6, 1986, is authorized to work in the United States.	Citizen and noncitizen identification	U.S. Dept. of Homeland Security, U.S. Citizenship and Immigration Services; Immigration Reform and Control Act of 1986, Pub. L. 99-603(8 USC 1324a)	Mandated
Form W-4, Employee's Withholding Allowance Certificate	Tax reporting	For employee identification	I.R.C. Section 6109	Mandated
Florida retirement contribution reports and forms (Florida Department of Revenue)	Administration of pension benefits	For employee identification	Section 119.071(6)(g), F.S.	Business Imperative
Worker's Compensation Amerisys forms on behalf of Risk Management, STARS reports of lost wages and First Report of Injury	For report and documentation of work-related injury and follow up	For employee identification	Section 440.185(2)(b), F.S.	Mandated
I.R.C. Section 403b,457b contribution reports (Internal Revenue Service)	Employee enrollment and claims	For employee identification	I.R.C. Section 6109	Mandated
State of Florida New Hire Report (Department of Revenue)	Administration of various programs: child support enforcement, Medicaid, unemployment compensation, Food Stamp, aid to disabled, etc.	New hire identification	Section 409.2576, F.S.	Mandated
State sponsored insurance enrollment forms and reports (group health, life, and dental coverage) (limited to dependents)	Administration of health benefits	Dependent identification	Section 119.071(6)(f), F.S.	Business Imperative
Agency for Workforce Innovation Unemployment Compensation forms	Verification of benefits eligibility	Employee identification and verification with Social Security Administration	Section 443.091(1)(g), F.S.	Mandated
FICA Alternative Plan Forms (OPS Retirement)	Selection of 401(a) Investment options and Beneficiaries	Reporting	(OBRA 90) IRC 3121(b)(7)(F).	Business Imperative

CHARDSNYDER™
Benefit Solutions

Letter of Medical Necessity Form

COMPANY INFORMATION

State of Florida

PARTICIPANT INFORMATION (PLEASE PRINT)

Last Name	Primary Phone ( ) -
First Name	Secondary Phone ( ) -
SSN (or People First ID)	Date of Birth (mm/dd/yyyy) / /

If the letter of medical necessity is required for claims for your spouse or eligible dependent, please provide the following information:

PATIENT NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH
		/ /

MEDICAL NECESSITY (TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER)

DIAGNOSIS:	**CPT CODE:**

RECOMMENDED TREATMENT:

EXPLAIN HOW THIS TREATMENT WILL ALLEVIATE THE DIAGNOSIS OR SYMPTOMS OF THE MEDICAL CONDITION:

DATE RANGE OF TREATMENT	From / / through / /

HEALTH CARE PROVIDER INFORMATION AND CERTIFICATION

Provider Name

Provider Phone	License #	State

By signing below, I certify that this service or product is medically necessary to treat the specific medical condition described above and is not for general good health or cosmetic purposes.

Licensed Health Care Provider's Signature:	**Date** / /

PARTICIPANT CERTIFICATION

By signing below, I certify that the previous Medical Necessity and Provider Information and Certification sections were completed by the above treating health care provider. The expense I am claiming is not for general good health or cosmetic purposes. The expense is due to the direct result of the medical condition as described above and would not have been incurred but to treat the medical condition as recommended by the health care provider. I also understand that this letter of medical necessity does not guarantee that the expense will be reimbursed under my plan.

Participant Signature (required)	**Date** / /

SEND THIS FORM TO CHARD SNYDER

Send the completed form with the signature of the health care provider and participant to Chard Snyder using one of the following:

☑ **Fax:** 888.245.8452 **(Please DO NOT include a fax cover page.)**
☑ **Mail:** 3510 Irwin Simpson Road, Mason, OH 45040

Letter of Medical Necessity Instructions

Under Internal Revenue Service rules, some health care services and products are only eligible for reimbursement from your health care FSA when your licensed health care provider (provider) certifies that they are medically necessary. The expense also would not have been incurred but for the direct result of treating the specific diagnosed medical condition. **Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.**

Chard Snyder has developed this form to assist you and your provider in providing the information we need in order to process your claim. Your provider can also submit a statement on his or her letterhead as long as the letter includes **all** of the information on this form. (This form is not used for reimbursement of over-the-counter medications. Those items require a doctor's prescription.)

For fast and accurate processing of your reimbursement request, please make sure to include this letter of medical necessity form or your provider's letter and itemized receipts or other documentation. If you are claiming membership to a health club, you must not already be a member of a health club and will need to submit documentation showing the membership was obtained after your provider's recommendation. The reimbursement request claim form can be found on the Chard Snyder website. Please be sure to print the requested information clearly on all documentation submitted.

Please note: *If your treatment extends beyond the time period listed by the provider, you will need to submit a new letter of medical necessity form upon expiration of the initial treatment dates. The maximum time period provided on the form cannot exceed one year from the date of the provider's signature. If treatment extends beyond one year, a new form will be required at the end of each one-year period.*

Fax or mail this form and supporting documentation directly to Chard Snyder:

- ☑ **Fax:** 888.245.8452 **(Please DO NOT include a fax cover page.)**
- ☑ **Mail:** 3510 Irwin Simpson Road, Mason, OH 45040

If you have questions please contact us:

- ☑ **Call Customer Service:** 855.824.9284
- ☑ **Visit our Website:** PeopleFirst.MyFlorida.com
- ☑ **Email your questions:** FloridaAskPenny@chard-snyder.com For security reasons, please do not send claims or personal information through email

Submission of this form is not a guarantee that the expense will be reimbursed.