Medical Necessity Form

This form must be completed and included with any reimbursement request you submit for "dual-purpose" expenses. Per IRS regulations, dual-purpose expenses are only eligible if recommended by a medical practitioner, as they have both a medical purpose and a personal, cosmetic, or general health purpose. Missing information may delay your reimbursement, or result in denial of your reimbursement request.

Step 1: Account Holder Information

Please complete the form in its entirety. Missing information may result in the denial or delay of your reimbursement request.

Employer Name: ____

Account Holder Name (First, MI, Last): ______________________________

Birth Date (MM/DD/YYYY): ____________ Social Security Number: ____________ Telephone: ____________

Address: ____________________ City: ______________ State: ____ Zip: ________

Step 2: Claim Information

Is this form being submitted for a previously denied claim?

☐ Yes ☐ No

If yes, please provide the claim number(s) for which you are submitting this form. Failure to provide the appropriate claim number(s) will result in the Medical Necessity Form being added to your account (if approved) and previous claim denials not being reprocessed.

____________________ ____________________ ____________________
Claim Number (1) Claim Number (2) Claim Number (3)

Step 3: Medical Practitioner Information

______________________________________ ______________
Name of and Type of Medical Practice Phone Number

______________________ ______________________ ________
Medical Practitioner or Physician Printed Name Medical Practitioner or Physician Signature Date

Step 4: Medical Necessity Information

______________________ ______________________________
Recipient of Treatment (First, MI, Last) Medical Diagnosis or Diagnosis Code Example: 724.2 (Lumbar Back Pain)

____
Treatment Recommended Example: massage therapy is required for 12 months

______________ ____________________ ____________________
Treatment Start Date Frequency of Treatment (1 time per week) Duration of Treatment

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Step 5: Participant Certification

I certify that the reimbursement requests I am submitting are eligible expenses as defined by the IRS and these expenses have been incurred by me, my spouse or my tax-qualified dependent. These expenses have not been reimbursed and are not reimbursable under any other plan, such as an individual policy or my spouse's or dependent's plan. I understand that BenefitWallet, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. By submitting this request, I certify that the information provided is complete and accurate. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement in the event of an IRS audit and I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse's income tax return.

______________________________ ____________________

Account Holder Signature Date

Step 6: Submit

For fastest results please submit your claim online. Otherwise, you will need to fax or mail this form along with your supporting documentation.

By Fax:
877.841.1153

By U.S. Mail:

BenefitWallet
PO Box 18010, Suite B
Norfolk, VA 23501

If you have any questions, please contact the BenefitWallet Service Center. Log into your online account at **www.mybenefitwallet.com** to submit claims online or to retrieve additional account information.

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