Letter of Medical Necessity

Under Internal Revenue Service (IRS) rules, certain expenses are eligible for health care account reimbursement only when accompanied by a Letter of Medical Necessity.

- Please have your health care provider complete the form below.
- Submit this form along with required documents. You may submit this information by upload, fax or postal mail:
  o Documentation Upload – Scan this letter and documentation. Log in to your online account, click on this claim’s details, and follow the instructions to upload this letter and documentation.
  o Fax or Postal Mail – Log on to your online account, click to add a new claim (or, if this claim is already in the system, click on this claim’s details), print the bar-coded Claim Submission Form, and follow the fax or postal submission instructions. If you received a bar-coded Claim Letter in the mail, you may use that instead of printing a Claim Submission Form.

*Please keep a copy of all submitted documents for your records.*

- If a claim requires a Letter of Medical Necessity, the claim will not be paid until the Letter of Medical Necessity and any required supporting documentation is received.
- An updated Letter of Medical Necessity is required each year. This form is valid for one year from the date of signature.
- This form does not guarantee approval. The claim is still subject to review.

Do not use this form for over-the-counter medications; a physician’s prescription is required. Effective January 1, 2011, over-the-counter medications will not be eligible for health care account reimbursement unless prescribed by a physician. This change is in accordance with the Patient Protection and Affordable Care Act. To be reimbursed for over-the-counter medications, a valid prescription is required to be submitted along with the claim.

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Employee Name

Patient Name (if different from Employee Name)

This section should be completed by the attending physician to confirm treatment is necessary for a specific medical condition.

Describe the diagnosed medical condition being treated: __________________________________________

Describe the required treatment: ______________________________________________________________

This treatment is medically necessary to treat the specific medical condition noted above. This treatment is not in any way for general health; and is not for cosmetic purposes to improve appearance.

Provider Signature ___________________________ Date ____________

Provider Name (Please Print) ___________________________ Provider License # ___________________________ Provider Telephone Number ___________________________