



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:
 - 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.
 - 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.

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