Letter of Medical Necessity

Some health care services and products are only eligible for reimbursement from the Health Flexible Spending Account when your provider certifies the expenses are medically necessary. Your provider must indicate the specific medical condition/diagnosis, the specific treatment needed and the duration of the treatment.

This letter has been developed to assist you and your health care provider in providing the information needed for your claim to be reviewed. Your provider may submit this information on his or her letterhead, as long as the letter includes the necessary information. Submitting this form does not guarantee the expense is eligible.

Please note a written prescription is required for over-the-counter medications. Please do not use this form to submit over-the-counter medications.

To Be Completed By Participant – Please print
Patient Name
Participant Name and Last Four Digits of the Social Security Number
Name of Participant's Employer
To Be Completed By Licensed Provider
Medical Condition / Diagnosis
Describe Recommended Treatment
Duration of Treatment (if longer than one year from the date of this letter, a new letter will be required after the one year period ends)

I certify this service or product is medically necessary to treat the specific medical condition above and is not in any way for general health or for cosmetic purposes.

Print Name, Address and Telephone Number of Licensed Provider
Signature of Licensed Provider
Date

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