Letter of Medical Necessity

Employee/Participant Name

The Internal Revenue Service rules and regulations, some health care services, treatments and products are only eligible for reimbursement from your Medical Flex Spending Account (Med-FSA) or Health Reimbursement Arrangement (HRA) if your Physician/Nurse Practitioner certifies that the expense is medically necessary to treat a specific medical condition, injury or illness. A diagnosis of general health, good health, preventive care or stress relief is not sufficient.

This Letter (or equivalent prescription) will expire one (1) year from the date of the provider's signature.

- As a general rule, the Letter of Medical Necessity (LMN) is to be completed by a "physician" (M.D., D.O., or N.D. or other individual authorized by the state to to write prescription script, such as a Physician's Assistant or Nurse Practitioner.) Other professionals, such as a Chiropractor or Acupuncturist, can complete this form if they are prescribing vitamins, herbal or homeopathic remedies to treat a condition diagnosed by the physician. Documentation of the diagnosis from the Physician or Nurse Practitioner must accompany this form.
- The name of the patient, a diagnosis of a specific medical condition and a specific recommendation is required each item. Multiple product or treatment recommendations can be made for a single diagnosis on a single line.
- Use of the LMN is not required; Letters on the provider's letterhead and prescription scripts are equally acceptable.
- A completed LMN (or equivalent) must be submitted with each claim that includes the item(s) prescribed.

EMPLOYEE/PARTICIPANT CERTIFICATION: By submitting this letter with my claim(s), I certify that the expenses related to this form are a direct result of the medical condition(s) described below, and I would not incur the expenses if not for the medical condition(s) indicated. I certify that the information reported in this document is true and accurate to the best of my knowledge. Finally, if the claim includes the cost of a membership to a gym/health club, I certify that I was not a member of a gym/health club prior to the recommendation of my physician.

EMPLOYEE/PARTICIPANT SIGNATURE	Date Signed:
X	

#			
1	Patient	Diagnosis	
	Prescription: Recommended Treatment, Service, Medication or Product (Including Frequency/Duration/Direction/Quantity of Treatment)		Generic OK? __ Yes __ No
2	Patient	Diagnosis	
	Prescription: Recommended Treatment, Service, Medication or Product (Including Frequency/Duration/Direction/Quantity of Treatment)		Generic OK? __ Yes __ No
3	Patient	Diagnosis	
	Prescription: Recommended Treatment, Service, Medication or Product (Including Frequency/Duration/Direction/Quantity of Treatment)		Generic OK? __ Yes __ No
4	Patient	Diagnosis	
	Prescription: Recommended Treatment, Service, Medication or Product (Including Frequency/Duration/Direction/Quantity of Treatment)		Generic OK? __ Yes __ No

Name of Medical Provider	Title/Degree	
Address of Medical Provider	License Number	State of Issue
	Phone Number	
Signature of Medical Provider	Date Signed	