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 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 form CANNOT be used to prescribe or recommend Over The Counter (OTC) Medications. A formal prescription "Script" form is required for reimbursement of OTC medication. This letter – as well as any prescription Script – will be deemed expired 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 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 or Product (Including Frequency/Duration/Direction/Quantity of Treatment)	
2	Patient	Diagnosis
	Prescription: Recommended Treatment, Service or Product (Including Frequency/Duration/Direction/Quantity of Treatment)	
3	Patient	Diagnosis
	Prescription: Recommended Treatment, Service or Product (Including Frequency/Duration/Direction/Quantity of Treatment)	
4	Patient	Diagnosis
	Prescription: Recommended Treatment, Service or Product (Including Frequency/Duration/Direction/Quantity of Treatment)	

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