



LETTER OF MEDICAL NECESSITY

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your health care FSA, limited purpose FSA, and HRA when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must indicate your (or your qualified dependent's) specific diagnosed medical condition, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.

This letter will assist you and your health care provider in providing the information needed in order to process your claim. You only need to submit this form or your provider's letter containing the same information with the first claim you submit for the service or product.

If the treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new letter of medical necessity each year—services cannot be approved indefinitely.

Patient Name _____

Participant Name _____

Participant's Employer _____

Participant SSN: _____

Complete the following:

1. Describe the diagnosed medical condition being treated. (include diagnosis code):

2. Describe the recommended treatment:

3. Indicate the duration of treatment:

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

Signature of Attending Physician

Date

Physician's Name Printed

Phone Number

Physician's Address

City

State

Zip Code

When complete return to:

Higginbotham, Attn: Flex Department, 1300 Summit Ave. Suite 750, Fort Worth, TX 76102

Fax: 1-866-419-3516 or (817) 882-9267

E-mail: flexclaims@higginbotham.net