



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 Flexible Spending Account or Limited Purpose Flexible Spending Account when your doctor or other licensed health care provider certifies that they are medically necessary.

By submitting this letter you certify that the expenses you are claiming are a direct result of the medical condition described below and you would not incur the expense if you were not treating this medical condition.

You only need to submit the form, or your provider's letter containing the same information, with the first claim you submit for the service or product being recommended. This will stay in effect for the time period listed by your provider, but not to exceed one year. If treatment continues beyond the listed time period, a new letter will be required.

| To Be Completed By The Participant | |
|--|--|
| Patient Name: | |
| Participant Name: | |
| Participant Employer: | |
| Last Four Digits of Participant's SS#: | |

| To Be Completed By The Provider | |
|---|-------|
| Medical Diagnosis: | |
| Recommended Treatment: | |
| Duration of Treatment: | |
| By signing this form, I certify that the service or product listed is medically necessary to treat the specific medical condition described above and is not for general health or cosmetic purposes. | |
| Provider Signature: | |
| Print Provider Name: | Date: |
| Provider Facility Name: | |

DBSbenefits.com

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