Innovative Business Consultants

Flex Spending Account Letter of Medical Necessity

Patient Name: _____Employer Name: _____

Employee Name: _____

This form should be completed by the medical practitioner to confirm treatment is necessary for a specific medical condition. This form is strictly confidential and will be used only for the proposes of processing claims. **This form must be submitted every plan year.** Complete the following:

Diagnosis:

_____

CPT Code (s):

_____

Specific recommended treatment:

_____

_____

Start date of treatment: _____/_____/_____

End date of treatment: _____/_____/_____

Certification

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

Signature of Medical Practitioner:_____

Print Physician Name:_____

NPI #: _____Tax Id #: _____

Facility:_____

Address:_____Phone:_____

City:_____State:_____Zip Code:_____

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LETTER OF MEDICAL NECESSITY INSTRUCTIONS

According to the Internal Revenue Service (IRS), some health care services and products are only eligible for reimbursement from your health care spending accounts when your doctor or provider certifies that they are medically necessary.

Your provider must indicate:

- Your (or your spouse's or dependent's) specific diagnosis
- The specific treatment needed
- The start and end dates of treatment
- Certification that the treatment is medically necessary

Your provider can also submit a statement on his or her letterhead, as long as the letter includes **all** of the following information on the form, including the certification of medical necessity.

By submitting the Letter of Medical Necessity, you certify that the expenses you are claiming are a direct result of the medical condition described, and you would not incur expenses if you were not treating this medical condition.

You only need to submit this form with the first claim you submit for the service or product. If the treatment extends beyond the time period listed, you must submit a new Letter of Medical Necessity covering the new time period.

You must submit a new letter of medical necessity each plan year —— they cannot be approved indefinitely.

Submitting this form does not guarantee that the expense will be reimbursed.

Your provider can use the following guidelines when completing a letter of medical necessity:

- The diagnosis must be specific. For example, a diagnosis of "elevated levels of triglycerides or cholesterol" is not specific. A diagnosis of "hypercholesterolemia" is specific.
- The recommended treatment must be named and described in detail by your licensed health care provider. A recommended treatment described as "regular or daily exercise recommended for weight loss" is not enough information. Your provider must specifically name and describe the recommended treatment. An acceptable description of treatment would be "I recommend an exercise program through a gym membership for the next six months to alleviate the patient's hypertension".
- Your provider must state a specific treatment period (with clear start and end dates). Lifetime or indefinite lengths of treatment will not be approved.
- Your licensed provider must complete, sign and date the form.