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LETTER OF MEDICAL NECESSITY

Your medical-care provider must complete this form for any service or product that falls under the category of "Maybe Expense" or "Ineligible Expense" per Sec 213(d), if your provider believes the service or purchase is *medically necessary* for you or your eligible dependent(s). You may obtain a list of eligible and ineligible expenses, as well as an FSA Claim Supporting Statement, online at www.benefitadministrators.com.

TO BE FILLED OUT BY PARTICIPANT
Patient Name:
Participant Name:
Participant Employer:
Last 4 Digits of Social Security Number:

TO BE FILLED OUT BY LICENSED PRACTITIONER
Medical Condition:
Describe Recommended Treatment: include the specific service/item and frequency and dosage
Duration of Treatment: (If a chronic condition, such as multiple sclerosis, please indicate "lifetime" as the duration of treatment)
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.
Print Name of Licensed Practitioner
Signature of Licensed Practitioner
Date

IMPORTANT: For the above expense noted on this form to be reimbursed, complete an an FSA Claim Supporting Statement and attach an itemized receipt or Explanation of Benefits (EOB) from your health insurance carrier.
Your documentation must include:

1. Name of Patient
2. Name of Provider
3. Date of Service
4. Description of Services Rendered or Product Purchased
5. Amount charged.

In addition, certain expenses may require additional supporting documentation. Please note: These documents are required with each claim you submit.