

LETTER OF MEDICAL NECESSITY

Instructions

Some healthcare reimbursement requests require additional information in order to be reimbursable through a Flexible Spending Account Plan. A new letter of medical necessity must be obtained each plan year in which you request reimbursement of items or services prescribed for the diagnosis listed below or at anytime the treatment plan changes. Please complete Section I of this form and have the attending physician complete Section II. Submit the completed form with each request for reimbursement.

Please note: Due to Health Care Reform, effective 1/1/2011, over-the-counter (OTC) medicines and drugs (except for insulin) will require a prescription from your physician to be reimbursed from your Health FSA. IRS Notice 2010-59 defines "prescription" as (a) a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and (b) that is issued by an individual who is legally authorized to issue a prescription in that state. This form does NOT meet those requirements.

I. Participant Information

Participant Name (Last, First, MI)

Participant I.D. Number

Participant's Employer

Patient's Name

II. Physician Information (to be completed by attending Physician)

Please provide a complete description of the diagnosed medical condition including the diagnostic code for the patient named above. Describe, in detail, the prescribed treatment plan.

Medical Condition: _____

Date treatment began or will begin: _____ / _____ / _____
month day year

Anticipated last day of treatment: _____ / _____ / _____
month day year

Treatment plan (medicines, drugs, services, procedures, equipment or supplies): _____

Physician Authorization

I hereby certify that the treatment plan listed above is medically necessary to treat the ailment or medical condition listed above. This treatment plan is neither for cosmetic reasons nor for general health and well-being.

Physician Name (please print) _____

Physician Signature _____ Date _____

Fax completed form to:
763.278.4004
toll-free 866.278.4004

Mail completed form to:
Acclaim Benefits - FSA Department
P.O. Box 47338
Minneapolis, MN 55447

Contact Acclaim Benefits:
763.278.4312
toll-free 800.333.3724
fsaCSR@acclaimbenefits.com