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 submitted 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 form to Acclaim Benefits.

Participant Information

_____ Participant Name (Last, First, MI)

_____ Participant I.D. Number

_____ Participant's Employer

_____ Patient's Name

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:

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

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

Please describe in detail, the prescribed treatment plan including any prescribed over-the-counter medications or products:

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