Letter of Medical Necessity (LMN)

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Care Flexible Spending Account (HCRFSA) or Limited Expense Health Care Flexible Spending Account (LTDFSA) when your doctor or other licensed health care 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 length of treatment, and how this treatment will alleviate your medical condition.

This letter is intended to assist you and your health care provider in providing the information needed in order to process your claim. Your provider can also submit a statement on his or her letterhead, as long as the letter includes all of the information on this form. By submitting this LMN you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition. You only need to submit this form, or your provider's letter containing the same information, with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new LMN each year – they cannot be approved indefinitely. Submitting this form does not guarantee that the expense will be reimbursed.

Note: All fields below are required.

<table>
<tr><td>Date:</td><td>Employer Name:</td></tr>
<tr><td>Employee Name:</td><td>SSN/FSA ID:</td></tr>
<tr><td>Patient Name:</td><td>Relationship to Employee:</td></tr>
<tr><td rowspan="2">Diagnosis:
_____Wound healing
_____First-Aid
_____Other (describe below)</td><td>Recommended Treatment:
Use Wonder Spray two to five times a day as needed.

How will treatment alleviate the diagnosis?
Treatment option has shown to improve this clinical condition.</td></tr>
<tr><td>Duration of treatment required: 12 months</td></tr>
<tr><td>Service Provider License # and State:</td><td rowspan="5"><u>Service Provider Stamp (if necessary)</u></td></tr>
<tr><td>Address:</td></tr>
<tr><td>City: State:</td></tr>
<tr><td>Zip Code:</td></tr>
<tr><td>Phone Number:</td></tr>
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