HRA/FSA Letter of medical necessity

Mail or fax completed form to you FSA/HRA/HSA administrator

Letter of medical necessity

According to Internal Revenue Service (IRS) rules, some health care services and products require a Letter of Medical Necessity in order to be eligible for reimbursement from your health care FSA, limited purpose FSA, HRA, or HSA. This letter must certify that your doctor or other licensed health care provider has deemed these services and/or products to be medically necessary. Your provider must indicate your (or your qualified dependent's) specific diagnosed medical condition, the particular treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.

Pelvic Tech LLC has created this form to help you and your health care provider in submitting the information required to process your claim with your FSA/HRA/HSA administrator. Your provider may also submit a statement on his or her letterhead, assuming the letter includes all the required information, included on this form.

You are only required to submit this form or your provider's letter containing the same information with the first claim you submit for the service or product. If the treatment extends beyond the time period listed (or longer than one year) you must submit a form or physician letter covering the new time period. Submitting this form does not guarantee that you will be reimbursed for the expense.

Account holder information

Company name -	Last 4 of SSN -		
Last name -	First name -		M.I. -
Street address -	City -	State -	ZIP -
Email address (required) -	Daytime phone (-) -	Work phone (-) -	

Patient information

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition.

Patient name -	Diagnosis/Treatment (please print) -

Describe the diagnosed medical condition being treated:

-

Describe the recommended treatment (Must be specific. If recommending supplements, herbs, or exercise equipment, list specific name(s) and itemize). Reimbursements will be made according to listed items only.

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How will the treatment alleviate the diagnosed condition? -

Treatment time period (not to exceed 12 months): Start date to End date

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health and is not for cosmetic purposes to improve appearance.

Physician name (please print) -		Signature of physician
Provider license number -	Date	Provider phone number -
Provider address -		