



Flexible Spending Account Letter Of Medical Necessity

Participant Name: _____

Participant SS#: _____

Participant's Employer: _____

Please have the attending physician complete this form confirming treatment is necessary for a specific medical condition and fax to the Flexible Spending Department at 888.285.5123, or mail to our corporate office.

1. Please state the diagnosis code and medical condition being treated.

2. Please state the recommended treatment. (Indicate the duration of treatment):

This treatment is medically necessary for the diagnosed condition stated above. The treatment is not, in any way, for cosmetic purposes to improve appearance or for general health.

Signature of Attending Physician

Date

Print Name

Address: _____ Phone: _____