________ Plan Year FSA
LETTER OF MEDICAL NECESSITY

Flexbene
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Under Internal Revenue Service (IRS) Rules, some health care services and products are only eligible for reimbursement from your Health Care Flexible Spending Account (HCFSA) when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must *specifically* state your (or your spouse's or dependent's) diagnosis, specify how the product and/or service is intended to alleviate symptoms or improve treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.

This form is to assist you and your health care provider in providing the information we need in order to process your claim. Your provider can also submit a statement on his or her letterhead so long as the letter includes **all** information on this form.

By submitting this LMN, you AND your licensed practitioner certify that the expense you are claiming is a direct result of the medical condition described below, and you would not incur the expense you are claiming if you were not treating this medical condition.

You only need to submit this submission 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, you must submit a form or physician letter covering the new time period. You must submit a new LMN each plan year- they cannot be approved indefinitely. Submitting this form does not guarantee that the expense will be reimbursed.

[Date of Completion]	[Mailing Address OR Email Address]
[EMPLOYEE Name]	[Last 4 digits of EMPLOYEE SSN]
[PATIENT Name]	

BELOW TO BE COMPLETED BY LICENSED PRACTITIONER

[Diagnosis/Medical Condition]	[CPT Code - REQUIRED]
[**DESCRIBE** Recommended Treatment - Including Frequency/Dosage]	
[**HOW** Will Treatment Alleviate the Diagnosis]	
[Duration of Treatment Provided]	
Provider Signature	[Provider Name – PRINT]
[Provider Address]	
[Provider License #]	[Provider Telephone #]

If you have questions you may visit the M.A. Services website www.flexbene.com or contact our office at 800-836-8100, Monday through Friday 9 am to 4:30 pm Eastern time. You may fax this completed form to 585-248-2488.

Note: MA Services role is to make sure that the proper documentation is submitted for reimbursement under the plan. MA Services will review this letter of medical necessity for completeness and to ensure treatment meets IRS guidelines and your employer's eligibility standards.

**** To prevent delay in review of your Letter of Medical Necessity (LMT), please be sure ALL boxes are filled out completely on this form or ALL information is included on your providers' letterhead ****