

*Flex*America
Letter of Medical Necessity

Please include the letter of medical necessity with each claim filing

This form should be completed by the attending physician to confirm treatment is medically necessary for a specific medical condition. Completing this form and requesting coverage for items specifically identified by the IRS as ineligible expenses, for example vitamins, will not permit reimbursement through your reimbursement account.

1. Enter the following information (please print clearly).

Employer _____

Employee Name _____

Social Security Number _____

2. Describe the diagnosed condition being treated:

3. Describe the recommended treatment:

4. Indicate the Duration of treatment:

5. Read the following and sign / date.

This treatment is medically necessary to treat the medical condition above. This treatment is not for general health purposes, to improve the appearance or for cosmetic services.

Physician Signature _____ Date _____

Print Name _____ Phone _____

Address _____