Certification of Medical Necessity

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your medical reimbursement account when your doctor or other licensed health care provider certifies that they are medically necessary.

IN ORDER TO PROCESS YOUR CLAIM: please have your health care provider complete this form, or provide a statement on his or her letterhead that includes the same information, then resubmit your claim along with a copy of the completed certification from your provider.

Each time you request reimbursement for this service/product, you will need to submit a copy of this form (or of your provider's letter) along with your completed claim form and receipt for the service or product. This form (or letter) will be valid for the indicated service or product for one year from the date on the form or letter, unless otherwise indicated by the Medical Provider below. At the end of one year, a new form or letter will be required.

Employee Name

Employer Name

PROVIDERS ONLY - Please complete the following:

Patient's Name

Diagnosis / medical condition

Recommended treatment/services/product

Date range of treatment provided *(MM/DD/YYYY)*

Please describe how the treatment/service/product impacts the medical diagnosis:

Please certify the following:

- This treatment is medically necessary to treat the medical diagnosis as described above.
- The treatment is not for general health or cosmetic purposes.

Signature

Date *(MM/DD/YYYY)*

Address

Phone Number

Please certify the following:

- The services indicated above are medically necessary (that is, required for the prevention or alleviation of a physical or mental defect or illness).
- I understand that I must submit a completed copy of this Certification of Medical Necessity form or a provider letter containing the same information with each request for reimbursement of this expense.
- I also understand that this form or letter from my provider will be valid for one year from the date on the form or letter, unless otherwise indicated by the Medical Provider above, and thereafter a new form or letter will be required.

Signature

Date *(MM/DD/YYYY)*