

# LETTER OF MEDICAL NECESSITY



Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Care Flexible Spending Account when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must indicate your specific diagnosis, the specific treatment needed and how this treatment will alleviate your medical condition.

myCafeteriaPlan has developed this letter 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, as long as the letter includes all the information on this form.

By submitting this letter you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition. If you are claiming membership to a health club, you certify that you were not already a member of a health club.

You only need to submit this form, or your provider's letter containing the same information, with the first claim you submit for the service or product being recommended. This will stay in effect for the time period listed by your provider but not to exceed one (1) year. If the treatment continues beyond the listed time period, a new letter will be required.

## TO BE COMPLETED BY THE PARTICIPANT

Employee Name

SSN

Patient Name

Email Address

Employer Name

Daytime Phone Number

## TO BE COMPLETED BY YOUR PROVIDER

Recommended service or product

Duration of Treatment

Diagnosis

CPT Code

Please describe the recommended treatment and how it will alleviate the diagnosis or symptoms of the medical condition listed above.

Provider Signature

Date

Provider License # and State

Provider Name - please print

Provider Phone #

myCafeteriaPlan

Fax: 937-865-6502

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