BUSINESSPLANS
MYBENEFITSTATEMENTS | MYCAFETERIAPLAN | MYCOBRAPLAN

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 (last 4 digits) _____

Patient Name _____ Email Address _____

Employer Name _____ Phone Number _____ Home Work

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.

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Provider Signature _____ Date _____ Provider License # and State _____

Provider Name - please print _____ Provider Phone # _____

Mail To: myCafeteriaPlan, 432 East Pearl St., Miamisburg, OH 45342
Fax To: 937.865.6502

Access your account information 24 hours a day, seven days a week on our web site: www.myCafeteriaPlan.com