CERTIFICATION OF MEDICAL NECESSITY

INSTRUCTIONS

Under Internal Revenue Service rules, certain health care services and products are eligible for reimbursement from your health flexible spending account (FSA) or health reimbursement arrangement (HRA) only when your physician or other licensed health care provider certifies that such services and/or products are medically necessary.

In order to process your claim, your physician/provider must complete this form (or provide a statement on his/her letterhead that includes the same information) and attach a prescription. Your physician/provider must (1) specifically identify the medical condition, (2) describe the recommended treatment for your medical condition, and (3) state a specific treatment period (with clear start and end dates).

You will need to submit a copy of this form (or of your physician's/provider's letter), and the corresponding prescription, each time you request reimbursement for a service/product. However, the physician/provider's certification will be valid for one year from the date on the form or letter. If you have any questions, please contact our Customer Service team at 1-877-268-3799 or (716) 505-8566, Monday-Friday 8 a.m. to 5 p.m. EST.

EMPLOYEE INFORMATION

Employee Name _____ Employer Name _____

MEDICAL CONDITION INFORMATION (to be completed by the physician/provider)

Patient's Name: _____

Medical Condition:_____

Prescribed Treatment or Service/Product:_____

Start Date of Treatment/Service/Use of Product:_____

End Date of Treatment/Service/Use of Product: _____

Please describe how the prescribed treatment/service/product will treat, prevent and/or alleviate the medical condition*:

_____

_____

_____

* For specialty food products – (1) the food must alleviate or treat an illness, (2) the food must not be part of normal nutritional needs, and (3) the need for food must be substantiated by the physician/provider. A substitute for food normally consumed and that satisfies nutritional needs **is not** medical care.

PROVIDER CERTIFICATION

This service/product is medically necessary to treat, prevent, and/or alleviate the medical condition as described above. The treatment is not for general health or cosmetic purposes.

Provider Name (please print) _____ Date _____

Provider Signature _____

EMPLOYEE CERTIFICATION

I certify that the service/product indicated above is 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 understand that submitting this form does not guarantee that the expense will be reimbursed.

Employee Signature _____ Date _____