BENEFITHelp Solutions

Letter of Medical Necessity

Date: ___/___/___

www.benefithelpsolutions.com • Ph: 503-219-3679 or 1-888-398-8057

Employer Name:

Member ID: Your Social Security Number or your unique ID Number assigned by your program sponsor.

Phone #: ___ - ___ - ___

Name: Last First M.I

This form is 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** of the information on this form. *The prescribed treatment or purchase of the over-the-counter (OTC) drugs must incur after the date in which the treating provider has completed this Letter of Medical Necessity form. If the treatment or purchase of the OTC is done prior to the completion of this form, then the expense is not eligible for reimbursement through your FSA/HRA plan.*

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

Medical care must be "for the diagnosis, cure, mitigation, treatment or prevention of disease." "Diagnose" means using any procedure to find out whether someone has a disease or dysfunction. Hearing, vision, blood tests, CT scans and urine analysis are all examples of diagnostic tests. "Cure" means a medical treatment or drug used to restore health such as using chemotherapy to treat cancer. For care to "mitigate," it must make a medical condition less harsh or severe. Examples include a wheelchair if a participant has multiple sclerosis and a seeing-eye dog for a blind child. "Prevent" requires that the care involves the immediate and proximate prevention of a disease, defect, or illness, and that the disease, etc. be imminent. An example would be if the provider prescribes an antibiotic to prevent infection from an animal bite. "*Expenses are not for the prevention of disease unless there is an existing or imminently probable disease, physical or mental defect, or illness.*"

OTC drugs, medicines and biologicals are eligible for reimbursement, as long as the request is accompanied by a provider's prescription. Items such as cough medicines, pain relievers, acid controllers, and diaper rash ointment require a provider's prescription to be submitted along with the reimbursement request. Insulin and other OTC items, such as band-aids, are eligible without a prescription.

You need to include this Letter of Medical Necessity form or your provider's letter containing the same information along with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form or provider letter covering the new time period.

Patient: Last Name First Name

Diagnosis:

CPT Code:

Treatment Start Date: ___ - ___ - ___

Please describe what the recommended treatment is, how that treatment will alleviate the diagnosis or symptoms, and the duration of the treatment required. Unless specified, this form will expire 12 months from the provider signature date and a new signed formed will be required to continue reimbursement of items/procedures.

PROVIDER

Name: _____ **Signature**: _____

License # and State: _____ **Telephone #**: _____

Web: www.benefithelpsolutions.com Phone: 503-219-3679 or toll-free 1-888-398-8057

Email: claims@benefithelpsolutions.com Fax: 888-249-5058

Note: BenefitHelp Solutions' role is to ensure that the proper documentation is submitted for reimbursement under the Plan, and not to determine whether the treatment prescribed by your provider or other licensed health care provider is medically necessary. BenefitHelp Solutions will review this letter of medical necessity only for completeness.

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