LETTER OF MEDICAL NECESSITY

Under IRS rules, some health care services and products are only eligible for reimbursement from your medical reimbursement account when your doctor or other health professional certifies that they are medically necessary.

ALL FIELDS MUST BE COMPLETED

EMPLOYEE INFORMATION

Effective Date
Start Date: **End Date:**

Account Holders Name:

Patients Name: **Last four of SSN:**

RECOMMENDATION DETAILS (COMPLETED BY THE PROVIDER)

Medication(s) or drug(s) or services recommended: (Please list supplements/vitamins individually)

_____

_____

_____

Physical or mental ailment this is attempting to diagnose, prevent, treat or cure:

_____

_____

You are recommending something that normally is not eligible for reimbursement from a Section 125 Flexible Spending Account. Please explain why this item/service is medically necessary:

_____

_____

HEALTH PROFESSIONAL INFORMATION

Certification: This treatment is medically necessary to treat the specific medical condition as described above. This treatment is not for general health or cosmetic purposes.

Name of Health professional

Signature of Health Professional **Date**

Attach this completed document to your 24HourFlex Claim Form and submit both documents via fax, email, or regular mail using the information below.

PO Box 3789
Littleton, CO 80161
Local Fax: 303-369-0003
Toll Free Fax: 1-800-837-4817
Email: claims@24hourflex.com

This information is strictly confidential and will beused only for the purpose of processing claims. You must have this form completed and submitted each plan year.