OVER-THE-COUNTER (OTC) MEDICATION PRESCRIPTION FORM

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) being prescribed: (If this is for vitamins or supplements, please use our Letter of Medical Necessity)

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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.