Fax completed form to: 866.932.2567
** Do Not Include Fax Cover Page **

or mail to: PayFlex Systems USA, Inc.
PO Box 3039, Omaha, NE 68103-3039

(Reminder, retain a copy of completed form for your personal records)

LETTER OF MEDICAL NECESSITY

To qualify for reimbursement from your account, expenses must be for a medical condition. Since some healthcare services and products, such as massage therapy and exercise, may be for both general good health and specific medical conditions, PayFlex may request that a Licensed Medical Practitioner confirm that an expense is recommended for the treatment of AND is a direct result of a specific diagnosed medical condition.

This form was designed to assist you and your health care provider in sending the information required to process reimbursement requests for this type of service or product. This form may be completed and signed by your physician (OR) your physician may submit the same information on signed letterhead stationery.

You will 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. However, if the treatment extends beyond the original treatment period listed, you must submit an updated form or physician letter for the new treatment period. For an ongoing condition, it is recommended that an updated Letter of Medical Necessity (LOMN) be submitted annually as treatment plans may change over time. Submitting this form or physician letter is not a guarantee that the expense will be reimbursed.

PLEASE PRINT CLEARLY

SECTION A ~ PARTICIPANT / PATIENT INFORMATION (To be completed by Participant)

Patient Name:

Participant Name:

Employer Name:

Member Number: _____________________ OR

Social Security Number: XXX–XX-___________

By submitting this LOMN, I certify that the expense(s) being claimed are a direct result of the medical condition described below, and that I would not have incurred the expense(s) if it were not treating this medical condition. If claiming for membership to a health club, I certify that I was not already a member of a health club.

Participant Signature: Date:

SECTION B ~ TREATMENT RECOMMENDATION (To be completed by Licensed Medical Practitioner)

Describe the diagnosed medical condition being treated:

CPT Code(s):

Recommended Treatment (Include any specific type(s) of service, treatment(s) or products(s) recommended):

Begin Date of Treatment: End Date of Treatment:

Practitioner Name:

Practitioner Address:

I certify that this service or product is medically necessary to treat a specific medical condition described above and is not for general good health or cosmetic purposes.

Practitioner Signature: Date:

Note: PayFlex's role is to ensure that the proper documentation is submitted for reimbursement under the Plan. PayFlex will review this letter of medical necessity for completeness and to determine if the treatment meets IRS eligibility guidelines.

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