

Letter of Medical Necessity Instructions

www.flexplan.com/lmn

Under Internal Revenue Service (IRS) rules, some health care services and/or products are only eligible for reimbursement if a legally authorized physician certifies that they are medically necessary.

This form is designed to assist you and your health care provider in providing the information necessary to process your claim(s). Your provider may also submit a statement on his/her letterhead, as long as the letter includes all of the information requested on the following page. If the form is incomplete or your provider's letter fails to include the required information, your claim(s) will be denied.

You must submit a new letter of medical necessity each year as the maximum period that can be authorized is 1 year. The expense you are seeking reimbursement for must be an eligible medical expense under the IRS tax code. If you plan to seek reimbursement from the Flex Plan, please be sure to review the Medical Expense Reimbursement list at www.flexplan.com/mrlist before purchasing the item or incurring the expense. **Submission of this form or your provider's letter does not guarantee that the expense will be reimbursed.**

Instructions to Health Care Provider:

- 1) Your provider should photocopy the form on the following page on their letterhead.
- 2) Your provider must complete the form with all of the requested information. If any item is incomplete, the form will be returned to the participant for the health care provider to recomplete and the participant's claim(s) will be denied. If you have any questions about this form, please contact Member Services at 323/993-8888 or 888/FLEX-401K, option 1.
- 3) The Provider must be a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Doctor of Nursing Practice (DNP), Certified Family Nurse Practitioner (FNP-C), or Institute for Functional Medicine Certified Practitioner (IFMCP) in the state they are practicing, and must sign, date and provide his/her license classification and federal registry number.
- 4) Return the complete executed form on the health care provider's letterhead to the participant to submit to the Flex Plan with his/her claim(s).

To be completed by Participant:

Patient Name: _____

Participant Name: _____

Account No or SSN: _____

To be completed by Provider:

Describe the diagnosed medical condition being treated: _____

Describe the recommended treatment: _____

Indicate the duration of treatment (may not exceed 1 year): _____

I certify that this treatment is medically necessary to treat the specific medical condition described above and is not for cosmetic purposes or for treatment which is merely beneficial to the general health of the individual.

Signature of Provider

Date

Printed Name

License Classification

Federal Registry No