region 1 | BENEFITS TODAY
Employee Benefit Administration Services

Letter of Medical Necessity

PLEASE NOTE – Any claims for over the counter (OTC) products, such as supplements, will not be accepted unless submitted with this Letter of Medical Necessity.

Under Internal Revenue Service (IRS) rules, some health care services and over the counter (OTC) products are only eligible for reimbursement from your Medical Expense Reimbursement Account when your doctor or other licensed health care provider certifies that they are medically necessary. This Letter of Medical Necessity was developed to assist you and your health care provider in providing the information needed to process your claim. Your provider must indicate the patient's specific diagnosis (including CPT or ICD-9 Code), the length of treatment, the recommended treatment and how this treatment will alleviate your medical condition.

You only need to submit this form with the first claim you submit for the service or product(s). However, if the treatment extends beyond the time period listed below, you must submit a new form covering the new time period. **Each year you are required to submit a new form – they cannot be approved indefinitely**. When filling out your Reimbursement Request, please be sure to note that you have a Letter of Medical Necessity on file with Region I. Even with this form, Region I still reserves the right to question the eligibility of the treatment in conjunction with IRS regulations. Submission of this form does not guarantee reimbursement of the claimed expense.

Section I: Employee Information (to be completed by participant)

Flex Participant Name: _____ **Employee ID**: _____
(Flex Plan ID)

Group #: _____ **Employer**: _____

Section II: Patient Information (to be completed by health care provider)

Patient Name: _____ **Date**: _____

Diagnosis: _____ **CPT or ICD-9 Code**: _____

Recommended Treatment: (Describe how the treatment will alleviate the diagnosed condition)

_____

List what specific medicines, drugs, equipment or supplies are required (You may use the back of this sheet for additional room.)

_____

_____

Duration of treatment: (Not to Exceed 12 months) _____

Provider Signature: _____ **License # & State** _____

Print Name: _____ **Phone**: _____

Provider Address: _____

_____

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