

# Letter of Medical Necessity

Patient Name: \_\_\_\_\_

This patient is diagnosed with: \_\_\_\_\_

\_\_\_\_\_

The service/program/equipment/prescription medication being prescribed for the treatment of the above condition and/or diagnosis: \_\_\_\_\_

\_\_\_\_\_

*\*\*Please note that gym memberships are **not** eligible\*\**

Duration of treatment must be specified. If the duration of treatment is not specified, this letter must be re-written for each new purchase/service:

One time only

Indefinite (Lifetime condition)

1 – 12 months (Chronic condition)

\_\_\_\_\_ Please specify the number of months needed for treatment of the chronic condition

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***PATIENT MUST KEEP THIS LETTER FOR TAX PURPOSES OR REIMBURSEMENT VIA FLEXIBLE SPENDING ACCOUNT, OR HEALTH REIMBURSEMENT ARRANGEMENT.***

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The **participant** must send this letter with a Request for Reimbursement form along with the appropriate documentation for approval of the expense.

Documentation must include:

1. Date of service/purchase.
2. Detailed description of service/purchase.
3. Charges minus any discounts or insurance payments.
4. Documentation for prescription drug purchases must include the drug names.
5. Credit card receipts cannot be used for the approval of an expense.