Letter of Medical Necessity

For Dual-Purpose Items and Services Only - Not For Over-the-Counter Medications

Some health-related expenses require additional documentation in order to be reimbursed by your FSA. These include dual-purpose items and services such as weight loss treatments, massage therapy, vitamins, and nutritional supplements. In some cases these are for general good health and are therefore not eligible. In other cases they are required to treat a specific medical condition and are eligible for reimbursement when recommended by your healthcare service provider.

To be reimbursed for these dual-purpose items, you may take this form to your doctor or service provider for completion and then submit it to ProBenefits along with your claim form and documentation of the expense. We will then keep this form on file and approve related claims for one year from the date that it is completed by your healthcare provider, or for the duration of the recommended treatment, whichever is shorter. You may also submit a letter or form from your provider in place of this form, as long as it contains all the information requested on this form. A Letter of Medical Necessity will need to be re-submitted each year or each time the treatment changes.

Participant Name: ______________________________

Participant Employer: ______________________________

Patient Name (if other than participant): ______________________________

To be completed by healthcare provider:

Patient: ______________________________

Medical Condition: ______________________________

Treatment Duration* (dates): From ____________________ to ____________________

**Please note: This Letter will be kept on file for one year, or until the end of the treatment duration, whichever comes first.*

Recommended Treatment (specific medical treatment, supplements, equipment, supplies, or services):

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I hereby certify that I am currently treating the above-named patient for the indicated medical condition, and that the recommended treatment above is medically necessary to treat that condition. The treatment is not for general good health or for cosmetic reasons.

Healthcare Provider Name (please print): ______________________________

Healthcare Provider Signature: ______________________________

Date: ____________________

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