

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from health flexible spending arrangements (health FSAs) or health reimbursement arrangements (HRAs) when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition. Please use this form letter to assist you and your health care provider in providing the information we need in order to process your claim. By submitting this LMN you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition.

The LMN form only needs to be submitted once per plan year, provided the submitted LMN is accepted. You must submit a new LMN each year—they cannot be approved indefinitely. Submitting this form does not guarantee that the expense will be reimbursed.

*Name of person receiving treatment _____

*Date treatment was recommended _____

Email Address _____

*Employee Name _____

*Member ID (which may be your SSN) _____

*Provider Name _____

*Employer _____

*Diagnosis/ICD code _____

*CPTCode (if any) _____

*Please note this information is required.

*Specific Medical Condition	*Recommended Treatment	*How Treatment Will Aid Condition

*Provider Signature _____ | *Date _____

*Provider Name _____

*Provider Address _____

*Provider License Number _____ | *Provider Telephone _____

Mail to: Ameriflex Claims Department P.O. Box 269009 Plano, TX 75026

Email to: claims@myameriflex.com **Fax to:** 888.631.1038 Attention: Claims Department