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Letter of Medical Necessity

This form should be completed by the Flexible Spending Account Participant's treating Physician. Once completed and submitted to our office, it will remain on file for the duration of the treatment specified below.

Complete the following information. Please print clearly.

Participant's Employer: _____

Name of Participant: _____

Participant's SSN: _____

Specific Medical Condition:

Treatment that is considered medically necessary to treat, prevent or alleviate the specified medical condition:

Length of Time for necessary treatment:

Physician's Name: _____

Physician's Address: _____

Physician's Signature: _____ Date: _____