Employee | Letter of Medical Necessity

This Letter of Medical Necessity is used to verify that medical expenses not traditionally covered under your flex plan, are required due to a medical condition. You only need to submit this form once per plan year. Each year you are required to complete a new form.

When filling out your IntegraFlex FSA/HRA Claim Form, please be sure to note that you have a Letter of Medical Necessity on file with us. Even with this form, IntegraFlex still reserves the right to question the eligibility of the treatment in conjunction with IRS regulations.

EMPLOYEE INFORMATION *(completed by you)*

Name *(First, Last)* Employer

Employee ID *(First initial, last name, last four digits of SSN)*

PATIENT INFORMATION *(completed by Primary Care Physician)*

Describe diagnosed condition to be treated:

Describe required treatment:

Indicate duration of treatment:

Clinic Name Phone

Address City State Zip

By signing below, you agree that this treatment is required, medically necessary, and not for general health purposes, or for cosmetic reasons.

Physician Signature **Date**

Printed Name

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