LETTER OF MEDICAL NECESSITY FORM

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Please ensure form is completed and legible.

Under Internal Revenue Service (IRS) guidelines, certain health care services and products are only eligible for reimbursement from your Healthcare Flexible Spending Account when your doctor or other licensed health care provider certifies they are medically necessary. For example, these expenses include massage therapy, over the counter medicines, vitamins and supplements, gym memberships and weight loss program fees. Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed and the length of treatment.

You need to submit a new Letter of Medical Necessity each year. The services and products cannot be approved indefinitely. Submitting this form does not guarantee the expense will be reimbursed.

Date _____

Patient Name _____

Diagnosis _____

Recommended Treatment:

Length of Treatment Required _____

Provider Signature _____

By submitting this letter, you certify the expenses you are claiming are a direct result of the medical condition described above, and you would not incur the expenses you are claiming if you were not treating this specific medical condition. If you are claiming membership to a health club, you certify you were not already a member of a health club.

Employee Signature _____

If you have questions, you may contact us; toll free, at 1-800-300-9691 or 515-224-9400 Monday through Friday, 8:00 a.m. to 4:30 p.m. Central time.