LETTER OF MEDICAL NECESSITY

For your Flexible Benefit Plan

Plan Name: ______________________________

Example "ABC Company Flexible Benefit Plan" If you are unsure about your Plan Name please contact your human resources or benefits department.

SECTION 1. EMPLOYEE INFORMATION

______________________________ Name

______________________________ Last Four Digits of SSN

______________________________ Patient Name

______________________________ Phone Number

SECTION 2. ATTENDING PHYSICIAN TO COMPLETE

Detailed explanation of diagnosed medical condition being treated:

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Recommended treatment: Specific item and/or treatment being recommended and expected benefit as related to medical condition(s) listed above.

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Duration of treatment: *Please note that this letter is valid only for the current plan year. Ongoing treatment will require a new letter every plan year.

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SECTION 3. DISCLOSURE

I certify that the aforementioned treatment is medically necessary to treat a specific medical condition and that the treatment is not for general or cosmetic health conditions.

______________________________ Attending Physician's Signature

______________________________ Date

Physician's Name / Address / Telephone number or seal of medical provider

Submit electronically: https://secure.pensiondynamics.com/ or Fax: (844) 859-7309

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