Human Resource Administrators, Inc.

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Provider Certification of Medical Necessity

Please include this letter of medical necessity with your claim **for review.**

Any incomplete forms will be denied for completion

This form should be completed by the attending physician to confirm treatment is medically necessary for a specific medical condition. Dual- purpose items are defined as those that are generally known to be used for both a medical purpose and a personal, cosmetic or general health purpose. If services are approved as eligible for reimbursement through the Health FSA Account a new certification or letter must be sent with the first request for said item during each new plan year. Please be advised, completing this form and requesting coverage for items specifically identified by the IRS as ineligible expenses will not be reimbursed through your FSA reimbursement account. (Example: multi-vitamins)

Enter the following information (please print clearly).

Employer: _____

Employee Name: _____ Patient Name:

Recommended Service / Supplement:

_____

1. Describe the diagnosed condition being treated**:**

_____

_____

_____

2. Describe the recommended treatment plan to include dosage and / or frequency of service**:**

_____

_____

_____

3. Indicate the Duration of treatment:

_____

_____

Provider's Certification of Medical Necessity: Please sign below to indicate you have recommended this treatment and that you deem it medically necessary for the purpose of reimbursement under a Flexible Spending Account (IRS code 125) and this treatment is not for general health purposes, to improve appearance or for cosmetic services.

Print Provider Name: _____ Phone:

Tax ID Number: _____

Physician Signature:_____Date:_____

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Please note: The first claim submitted with this request must include a signed and dated claim form completed by the employee along with a copy of the expenses paid by the participant.

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