LETTER OF MEDICAL NECESSITY FORM

NCFLEX
STATE INSURANCE PLANS
NCFLEX.ORG

Sign this form and submit it to P&A Group.
Fax: (877) 213-8917
Mail: P&A Group 17 Court Street Suite 500 Buffalo, NY 14202

Certain Flexible Spending Account (FSA) items are eligible for reimbursement only if a letter of medical necessity is provided. The letter must include the diagnosis of a medical condition and state that the expense is necessary to treat the medical diagnosis. It must also include the length of treatment. Examples of expenses that are deemed as medically necessary in order to treat a medical condition (and therefore are eligible for reimbursement under the FSA plan) include massages, gym memberships and weight loss programs. Your physician must complete and sign the form below, thereby acknowledging that the medical expense is being used to treat a medical condition.

This form is valid for one year from the date of signature. A new form must be submitted annually.

EMPLOYEE INFORMATION

Company Name		Employee DOB
Employee Last Name	**Employee First Name**	**Last 4 Digits of SSN or Member ID #**
Patient Last Name (if different than above)	**Patient First Name (if different than above)**	

PHYSICIAN'S DIAGNOSIS

(This section must be completed by the attending physician to confirm if treatment is necessary for a specific medical condition.)

Healthcare Provider Name	Provider License No.	Healthcare Provider Phone No.
Diagnosis Date (mm/dd/yyyy)	**Treatment Start Date (mm/dd/yyyy)**	**Treatment End Date (mm/dd/yyyy)**
/ /	/ /	/ /
Please diagnose the medical condition being treated.		
Describe the required treatment.		

I assert that this treatment is medically necessary to treat the specific medical condition noted above. This treatment is not in any way intended for general health maintenance or cosmetic purposes.

Healthcare Provider Signature: X Date: / /