Letter of Medical Necessity

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from health flexible spending arrangements (health FSAs) or health reimbursement arrangements (HRAs) when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition. Please use this form letter to assist you and your health care provider in providing the information we need in order to process your claim. By submitting this LMN you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition.

You only need to submit this submission form with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form covering the new time period. You must submit a new LMN each year—they cannot be approved indefinitely. Submitting this form does not guarantee that the expense will be reimbursed.

Name of Person Receiving Treatment _____

Date _____ **Email Address** _____

Employee Name _____ **Employee SSN** _____

Provider Name _____ **Employer** _____

***Diagnosis** _____ **CPT Code** (if any) _____

*Please note this section is required.

Specific Medical Condition	Recommended Treatment	How Treatment Will Aid Condition

Provider Signature

Provider Name _____

Provider Address _____

Provider License Number _____ Provider Telephone _____

Mail to: **Ameriflex Claims Department** P.O. Box 269009 Plano, TX 75026
Email to: claims@myameriflex.com **Fax to:** 888.631.1038 Attention: Claims Department