



Letter of Medical Necessity

This form is to be completed when submitting “dual purpose” expenses. Per IRS regulations, dual purpose expenses are only eligible if recommended by a medical practitioner as they have both a medical purpose and a personal, cosmetic, or general health purpose.

Please complete and submit this form for any dual purpose expense for which you are requesting reimbursement. If submitting this form for a previously denied claim or debit card purchase, please include a copy of the denial notification or the appropriate form along with the itemized receipt or statement you originally submitted.

This form need only be submitted once for each specified medical diagnosis and recommended or prescribed treatment.

Patient Name:

This patient is diagnosed with:

The service/program/equipment/prescription medication being prescribed for the treatment of the above condition and/or diagnosis:

Duration of treatment must be specified. If the duration of treatment is not specified, this letter must be re-written for each new purchase/service:

- One time only
- Indefinite (Lifetime condition)
- 1 – 12 months (Chronic condition)

_____ Please specify the number of months needed for treatment of the chronic condition

Physician’s Signature:

Date:

Physician’s Comments:

The **participant** must send this letter with a Request for Reimbursement form along with the appropriate documentation for approval of the expense.

Documentation must include:

1. Date of service/purchase.
2. Detailed description of service/purchase.
3. Charges minus any discounts or insurance payments.
4. Documentation for prescription drug purchases must include the drug names.
5. Credit card receipts cannot be used for the approval of an expense.

PATIENT MUST KEEP THIS LETTER FOR TAX PURPOSES OR REIMBURSEMENT VIA FLEXIBLE SPENDING ACCOUNT, OR HEALTH REIMBURSEMENT ARRANGEMENT.