

# ***INTEGRATED BENEFITS***

## **ADMINISTRATION**

*Flexible Spending Accounts | Health Reimbursement Arrangements | Health Savings Account Administration | COBRA Administration*

### **Letter of Medical Necessity**

This Letter of Medical Necessity is used to verify that medical expenses not traditionally covered under your flex plan, are required due to a medical condition. You only need to submit this form once per plan year. Each year you are required to complete a new form.

When filling out your **Integrated Benefits Administration FlexHRA Claim Form**, please be sure to note that you have a Letter of Medical Necessity on file with us. Even with this form, **Integrated Benefits Administration** still reserves the right to question the eligibility of the treatment in conjunction with IRS regulations.

#### **Employee Information (to be completed by you)**

Name: \_\_\_\_\_  
(First, last)

Employee ID: \_\_\_\_\_  
(First initial, last name, last four digits of Social Security #)

Employer: \_\_\_\_\_

#### **Patient Information (to be completed by Primary Care Physician)**

Describe diagnosed condition to be treated: \_\_\_\_\_

\_\_\_\_\_

Describe required treatment: \_\_\_\_\_

\_\_\_\_\_

Indicate duration of treatment: \_\_\_\_\_

By signing below, you agree that this treatment is required, medically necessary, and not for general health purposes, or for cosmetic reasons.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_