FLEX BENEFIT AMINISTRATORS

Completed Forms can be emailed, mailed or faxed

Scan & email: claims@fbaflex.com

MAIL: PO BOX 800518 HOUSTON, TX 77280-0518 PHONE (713) 460-FLEX (3539)

FAX: (713) 460-3550

Letter of Medical Necessity

| | | <i>,</i> , , , , , , , , , , , , , , , , , , | |
|---|--|--|---|
| | Patient Name: | | |
| | Participant Name: | | |
| | Participant's Employer: | | |
| | Participant's Social Security Number: | | |
| approved physicia the requirements f are eligible under | n must be an MD, DO, DPM, OD, DC or DD or expense eligibility and the claim will not by your Health Care Spending account and expense. | d expenses are eligible under IRS Code Section 21 ps. Completion of this statement by any other hear he reimbursed. *Please note that an updated statement of the second prior to this recommendation will ented. (ICD-9 Code and initial date of diagonal contents of the second prior to the | Ith care professional will not fulfill nent is required each plan year you not be reimbursed. |
| | | | |
| Describe the sp | pecific (itemized products) recommen | nded treatment: | |
| | | | |
| Indicate the ler | ngth of treatment: | | |
| | | ndicated above will diagnose, cure, mitigeral good health or cosmetic procedures. | ate or prevent the medical |
| Signati | ure of Attending Physician | Printed Name | Date |
| Address: | | Phone: () | |
| | | ation is required in addition to the attend | |
| condition listed | | or educator providing this treatment spec | ianzes in treating the medical |
| Educat | or's Signature | Printed Name | Date |
| Address: | | Ph | one: () |