Medical Reimbursement Plan
Statement of Medical Necessity

Employee Data

Employer Name

Employee Name

Social Security Number

Description of Need for Information

The participant listed above has requested reimbursement of a medical related expense that would be determined ineligible for his or her Flexible Benefits plan without a specific physician's order or prescription. The following information is needed to verify that the expense is not simply for the claimant's general wellbeing or general health, but necessary for the treatment of a specific ailment.

Patient Information

Patient Name:

Relationship to Employee:

Medical Provider Information

Provider Name:

Street Address:

City, State and Zip:

Phone Number:

Treatment Plan/Statement of Medical Necessity

Please describe the medical necessity of the proposed treatment plan and any requirement for special medical services or devices.

Specific Medical Diagnosis:

Service/Equipment Prescribed:

Proposed Treatment Start Date:

Proposed Treatment End Date:

Provider Signature

I have prescribed the above referenced services/equipment for the treatment of the patient identified above. I certify to the medical necessity of the treatment plan outlined.

Date: Provider Signature: