Medical Reimbursement Plan
Over-the-Counter Prescription Form

Employee Data

Company Name:

Employee Name:

Employee Social Security or ID Number:

Description of Need for Information

The participant listed above has requested reimbursement for a medical related Over-the-Counter (OTC) expense that requires a prescription in order to be determined an eligible expense under the Flexible Benefits plan. The following information is needed to verify that the OTC expense listed below is being prescribed by a licensed physician for the treatment of a specific medical condition. This form is intended solely for use by Vita Flex and its participants.

Patient Information

Patient Name:

Relationship to Employee:

Over-the-Counter (OTC) Product Information

Product Name	Medical Condition Being Treated	Frequency of Use
		☐ Recurring ☐ One-Time
		☐ Recurring ☐ One-Time
		☐ Recurring ☐ One-Time
		☐ Recurring ☐ One-Time
		☐ Recurring ☐ One-Time
		☐ Recurring ☐ One-Time
		☐ Recurring ☐ One-Time

Provider Signature

I have prescribed the above referenced OTC product(s) for the treatment of the patient and medical condition(s) identified above. I attest to the medical necessity of the treatment and OTC product(s) prescribed above.

Date: Provider Signature:

Form Submission Methods

Online: www.vitaflex.net

Fax:
Vita Flex
(650) 964-FLEX (3539)
(866) 964-FLEX (3539

E-mail:
help@vitamail.com

Mail:
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