



Letter of Medical Necessity for your Flexible Benefit Plan

SECTION A – EMPLOYEE DATA (PLEASE PRINT OR TYPE)

Employer Name:

Employee Name:

Patient Name:

Home Phone:

SECTION B – ATTENDING PHYSICIAN TO COMPLETE

Detailed explanation of diagnosed medical condition being treated:

Recommended treatment:

Duration of treatment: ** Please note that this letter is valid only for the current plan year. Ongoing treatment will require a new letter every plan year.

SECTION C - DISCLOSURE

The treatment listed above is medically necessary to treat the specific medical condition. This treatment is not for General Health and/or cosmetic purposes.

Date:

Attending Physician Signature:

Physician's Address/Phone Number or Stamp:

PLEASE FORWARD COMPLETED FORM TO:

BENEFIT DYNAMICS

a division of Pension Dynamics Corporation

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