LETTER OF MEDICAL NECESSITY

For your Flexible Benefit Plan

Plan Name: _____

Example "ABC Company Flexible Benefit Plan" If you are unsure about your Plan Name please contact your human resources or benefits department.

SECTION 1. EMPLOYEE INFORMATION

Name _____ Last Four Digits of SSN _____

Patient Name _____ Phone Number _____

SECTION 2. ATTENDING PHYSICIAN TO COMPLETE

Detailed explanation of diagnosed medical condition being treated:

Recommended treatment: Specific item and/or treatment being recommended and expected benefit as related to medical condition(s) listed above.

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 3. DISCLOSURE

I certify that the aforementioned treatment is medically necessary to treat a specific medical condition and that the treatment is not for general or cosmetic health conditions.

_____ _____

Attending Physician's Signature Date

Physician's Name / Address / Telephone number or seal of medical provider

Submit electronically: **https://secure.pensiondynamics.com/** or Fax: (844) 859-7309