LETTER OF MEDICAL NECESSITY (LMN)

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Care Flexible Spending Account (HCFSA) or Limited Purpose Flexible Spending Account (LPFSA) when your doctor or other licensed health care provider certifies that they are medically necessary.

Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.

You may either submit the LMN with your medical claim, or you may submit the LMN prior to submitting a medical claim in order to determine if the expense will be eligible for reimbursement.

Please use the following guidelines when submitting an LMN:

- **The diagnosis must be specific.** For example, a diagnosis of "elevated levels of triglycerides or cholesterol" is not specific – a diagnosis of "hypercholesterolemia" is specific.
- **The recommended treatment must be named and described in detail by your licensed health care provider**. A recommended treatment described as "regular or daily exercise recommended for weight loss" in not enough information. Your provider must specifically name and describe the recommended treatment. An acceptable description of treatment would be "I recommend an exercise program through a gym membership for the next 6 month to alleviate the patient's hypertension." If you are claiming a membership to a health club, you must certify that you were not already a member of a health club.
- **Your provider must state a specific length of treatment (not to exceed 12 months**). Lifetime or indefinite lengths of treatment will not be approved. If the treatment is for a chronic condition, you only need to submit one LMN for the Benefit Period.
- Your licensed provider must complete, sign and date the form.

This form was developed to assist you and your health care provider in providing the information we need in order to process your claim. Your provider can also submit a statement on his or her letterhead, as long as the letter includes **all** of the information on this form.

By submitting this LMN you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition.

You only need to submit this form, or your provider's letter containing the same information, with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new LMN each year – they cannot be approved indefinitely.

Submitting this form does not guarantee that the expense will be reimbursed.

Date:	Email Address:
Account Holder's Name:	Account Holder's SSN:
Patient's Name:	
Diagnosis:	CPT Code:
Recommended Treatment:	
How will the treatment alleviate the diagnosis?	
Begin Date of Treatment:	End Date of Treatment: (not to exceed 12 months)
Provider Signature:	
Provider Name:	
Provider Address:	
Provider License #:	Provider Telephone #:

Note: All information must be complete on this form. Our role is to make sure that the proper documentation is submitted for reimbursement under the Plan. The Harrison Group, Inc. will review this letter of medical necessity for completeness and to ensure that the treatment meets IRS guidelines and Plan eligibility standards.

Please mail, fax, or email this form to the contact information below:

THE HARRISON GROUP, INC.
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