LETTER OF MEDICAL NECESSITY

Your medical care provider must complete this form for any service or product that falls under the category of "Maybe Expense" or "Ineligible Expense" per IRC Sec 213 (d) (1) if your provider believes the service or purchase is medically necessary for you or your eligible dependent(s).

TO BE FILLED OUT BY PARTICIPANT
Patient Name
Participant Name
Participant Employer
American Benefit Administrators Username or Last 4 Digits of Social Security Number

TO BE FILLED OUT BY LICENSED PRACTITIONER
Medical Condition
Describe Recommended Treatment (frequency and dosage)
Duration of Treatment (If a chronic condition, such as multiple sclerosis, please indicate "lifetime" as the duration of treatment)
I certify that this service or product is medically necessary to treat the specific medical condition described above and is not in any way for general health or for cosmetic purposes.
Print Name of Licensed Practitioner
Signature of Licensed Practitioner
Date

IMPORTANT: For the above expense noted on this form to be reimbursed, complete a FSA claim form and attach the detailed receipt or Explanation of Benefits (EOB) from your health insurance carrier. Your documentation must include the date of service, the services rendered or product purchased, the person for whom the services were rendered, and the amount charged. In addition, certain expenses may require additional supporting documentation. Please note: These documents are required with each claim you submit.

American Benefit Administrators, LLC

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