Letter of Medical Necessity for Flexible Spending Account (FSA)

*This is to use Flex dollars for a medical expense not normally considered an eligible expense (ex: weight loss programs, massage therapy, or over the counter medications). These expenses can be considered eligible with this form or a prescription.

Patient Name: ____

Employee Name: ____

Last four numbers of SSN: ____

Employer Name: ____

1. Describe diagnosed medical condition (include diagnosis code):

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2. List recommended service/equipment for condition:

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3. Duration of time service/equipment for condition is needed (maximum of one year):

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______________________________ Signature of Attending Physician

______________________________ Date

______________________________ Print Physician Name

______________________________ Print Facility Name

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