The BESTflex℠ Plan
Employee Benefits Corporation

Letter of Medical Necessity

Fax to: **608 831 4790**
Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347
Phone support: **800 346 2126** | 608 831 8445
E-mail support: **participantservices@ebcflex.com**

Account Holder Information

Last 4 Digits of Social Security or Identification Number (Required)

Last Name

First Name

E-mail Address (we do not share your e-mail address)

Employer

Patient Information

Patient Name

Relationship to Account Holder (self, spouse, son, daughter)

Physician/Service Provider Information

Please note: this document cannot be used to make over-the-counter (OTC) drugs or medicines eligible for reimbursement through the BESTflex Plan. OTC drugs or medicines require a legal (in your state) prescription in order to be reimbursed.

This section must be completed by the patient's physician or other health care provider responsible for the diagnosis and treatment plan.

(Please print clearly)

Health Care Provider Name

Health Care Provider Phone (000-000-0000)

Health Care Provider Fax (000-000-0000)

Onset of Diagnosis (mm-dd-yyyy)

Treatment Start (mm-dd-yyyy)

Treatment End (mm-dd-yyyy)

Medical Diagnosis:

Requested Service, Procedure, Equipment, Supplement/Vitamin, Supplies Or Capital Expenditure:

In the event the Duration of Treatment is "lifetime," Duration of Treatment will be entered into our system starting on the signature date below to last for 1 year from that date. A new Letter of Medical Necessity (this form) must be submitted annually.

I certify that I am qualified to diagnose and treat the patient. I certify that the prescribed treatment as detailed above is medically necessary to treat the specific diagnosis (medical condition) as defined above and is not intended to promote the patient's general health, well-being, is not for nutritional replacement, cosmetic purposes or is to serve as a personal, living or family purpose. The treatment is not excessive in nature and would not have been sought other than to treat this medical condition.

Health Care Provider's Signature

Date (mm-dd-yyyy)

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Frequently Asked Questions

What is a letter of medical necessity?

Eligible items that may be reimbursed through the Health Care FSA must be amounts for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body. In some situations, items may be considered personal in nature or be dual purpose (can be both medical and personal in nature).

When an expense is not clearly only for the treatment of a medical condition, additional information and certification must be obtained. The letter of medical necessity shows that the service, procedure or item is being used to treat a specific medical condition and is not personal in nature.

When would I seek a letter of medical necessity?

If you, your spouse or your dependent are seeking treatment, services or a specific item that is either personal in nature or is considered dual-purpose, a letter of medical necessity will be required for reimbursement. In an effort to provide convenience, this form has been developed so that all the information that is needed can be obtained in one easy form.

What are examples of items that require a letter of medical necessity?

Here is a small sample of services, treatments or items that may be considered personal or dual purpose but may be eligible with a letter of medical necessity. Items such as massage therapy, humidifiers, supplements, weight loss programs and dental veneers may be considered medical with proper documentation.

Instructions:

- Please clearly PRINT all information except for signatures
- All fields must be completed or the form will be returned
- A specific medical condition or diagnosis must be included
- Questions, call our Participant Services Department at 800 346 2126

How is reimbursement obtained?

Once you have obtained a completed and signed letter of medical necessity, submit it with a completed and signed Reimbursement Form and the invoice or receipt for the item or service. If you would like to pre-qualify the expense, you may submit the Letter of Medical Necessity alone. If the expense is still not eligible, you will be contacted with additional information.

What is a capital expense?

A capital expense is an item that is used for more than one plan year. Examples of capital expenses include elevators, bath tub railings, wheel chair access ramps and custom construction for a medical condition.

Capital expenses are divided into two categories. Those that are permanent fixtures in the home and those that are portable. The expenses that are portable can be reimbursed at 100% of the cost. If the item is a permanent fixture in the home, such as an elevator, only a portion of the cost may be reimbursed. The reimbursable portion of a permanent item is the cost of the item minus the increased value of the residence.

How often is a letter of medical necessity submitted?

Generally, a letter of medical necessity is required once each plan year even when the service or procedure extends beyond one year. If the original letter of medical necessity states a duration less than a year and the service or procedure will be required past the original duration, a new letter will need to be submitted. Lastly, if the treatment changes such as in the case of supplements, a new letter of medical necessity must be submitted.