Employee Benefits Corporation

Letter of Medical Necessity

Phone support: **(800) 346-2126** | (608) 831-8445
Email: **participantservices@ebcflex.com**

Account Holder Information

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

Last Name

First Name

Email Address (we do not share your email address)

Employer

Patient Information

Patient Name

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

Physician/Service Provider Information

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

Please diagnose the medical condition being treated:

Describe the recommended treatment:

Please be as specific as possible.

Explain why the treatment is medically necessary to prevent or alleviate the patient's condition:

If the treatment is for prevention of a condition, explain how the condition is imminently probable for the patient, which means that medical evidence exists to show the condition is highly likely to occur without the item or service.

Recommended Duration of Treatment:

Treatment Start (mm/dd/yyyy)

Treatment End (mm/dd/yyyy)

Treatment start and end dates are required. The end date cannot be more than 5 years from the date the letter is signed. A new letter is required after 5 years if a longer period is listed. If no end date is indicated, this letter will expire one year from the date of signing.

I certify that I am qualified to diagnose and treat the patient, and that the prescribed treatment as detailed above is recommended using my professional judgment to treat the specific diagnosis (medical condition) described above. I certify that I have personally diagnosed the patient or am working under the authority of a healthcare provider who has personally diagnosed the patient. I further certify that the treatment is not intended to promote the patient's general health or well being, and is not for cosmetic or personal purposes. I am not aware that the patient has used this service or purchased this product previously for any reason other than for its therapeutic value in treating their medical condition.

Healthcare Provider Name

Healthcare Provider Phone (000-000-0000)

Healthcare Provider Email

Healthcare Provider License Number and State

Healthcare Provider Address

X _____

Healthcare Provider's Signature

Date (mm/dd/yyyy)

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Frequently Asked Questions

What is a letter of medical necessity?

A letter of medical necessity provides a way for a healthcare provider to certify that an item that would otherwise be an ineligible expense is medically necessary to treat a specific medical condition, and therefore may be eligible for reimbursement.

When do I need a letter of medical necessity?

A letter of medical necessity is required for reimbursement if you, your spouse, or your dependent are seeking treatment, services, or a specific item that would typically be considered personal in nature. For example, wellness and fitness expenses are considered personal in nature, so a letter of medical necessity is required for them. Such expenses can only be reimbursed if they are medically necessary and not intended to promote a person's general health or well-being, and are not for cosmetic or personal purposes.

What items require a letter of medical necessity?

Any time a person seeks reimbursement from their FSA or HRA for expenses associated with a personal care item or service, a letter of medical necessity is required. Some common personal items that may be reimbursed with a letter of medical necessity include massage therapy, humidifiers, supplements, and weight loss programs.

How do I get reimbursed for my expense?

Submit the completed letter of medical necessity with your claim and the invoice or receipt for the item or service. You can do this through the EBCentral mobile app or your online account at www.ebcflex.com. **Submitting this form does not guarantee that the expense(s) will be reimbursed.**

How often do I need to submit a letter of medical necessity?

We use the treatment dates listed in your letter of medical necessity to determine how long the letter is valid, so it's important that start and end dates are included. You need to submit a new letter on the end date listed.

- If no end date is provided, you need to submit a new letter one year after the original letter's signature date.
- If your end date is more than five years in the future, you need to submit a new letter five years from the date of the signature.

If your treatment plan is extended beyond the dates listed in your original letter, make sure you get an updated letter from your healthcare provider and resubmit it to us so there is no delay in your reimbursements.

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