LETTER OF MEDICAL NECESSITY

Use this form to be reimbursed for healthcare products and services that require authorization from a Medical Practitioner to be considered eligible for reimbursement from a Flexible Spending Account (FSA).

INSTRUCTIONS

1) Complete the form on the following page:
    a. Complete **Section I** (including your signature and the date) *prior* to visiting your Medical Practitioner.
    b. Bring this form with you to your next medical appointment and request that the attending Medical Practitioner complete **Section II**. Instruct them to follow the specific pharmacy/prescription laws in their respective state when completing Section II.
2) You may use the same form for each individual in your household for whom you purchase healthcare products and services, as long as the same Medical Practitioner is completing the form.
3) You must submit a copy of this completed form to TASC with each Request for Reimbursement (if submitting online, include a copy with your receipts). Any *Letter of Medical Necessity* received without a Request for Reimbursement will not be processed.
4) The Letter of Medical Necessity will be considered effective for 12 months from the date signed by the Medical Practitioner, or until the end of the benefit plan year in which it was submitted. A new form must be submitted each plan year in which you request reimbursement, or any time the treatment plan changes.

DEFINITIONS *(for the purposes of this form)*

- "Letter of Medical Necessity" refers to any order for healthcare products or services signed by a licensed Medical Practitioner granted prescriptive authority by the laws of the state. It contains the name and quantity of the medicine/product/service prescribed, directions for use, and treatment duration.
- "Medical Practitioner" generally includes the following licensed health professionals: physician (MD/DO), physician assistant, nurse practitioner, dentist, optometrist and podiatrist.

Products and services that require a Letter of Medical Necessity or other Medical Practitioner authorization to show the expense is to treat a medical condition include the following:

Air Purifier	Exercise Equipment	Orthopedic Shoes (excess cost only)
Varicose Vein Treatment	Automobile Modifications	Massage Therapy
Special Foods (excess cost only)	Whirlpool/Spa	Ear Plugs
Nutritionist's Professional Fees	Support Hose	Wigs

STATE RESTRICTIONS

The Medical Practitioner's signature must be in ink (i.e., may NOT be pre-printed) in the states of:
Arkansas, Connecticut, Florida, Georgia, Idaho, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Virginia, and Washington.

The use of this form is prohibited; a prescription is required in:
Montana, Pennsylvania, and South Dakota.

LETTER OF MEDICAL NECESSITY

Include this completed form with your Request for Reimbursement online, or submit via fax or mail:	Fax	Mail
	(608) 663-2762	TASC, P.O. Box 7308 Madison, Wisconsin 53704-7308

SECTION I – PARTICIPANT AUTHORIZATION

First Name:		MI:		Last Name:	
TASC ID:		Email Address:			
Primary Phone:		Mobile Phone:			

The statements in this document are complete and true, to the best of my knowledge and belief. I understand that the IRS regulates my FSA account and that the guidelines are implemented as a means of ensuring compliance with FSA reimbursable expenses, and that TASC reserves the right to verify the eligibility of the expenses in accordance with IRS regulations. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests.

_____ _____

Participant's Signature **Date**

SECTION II – TREATMENT INFORMATION

To be completed by Medical Practitioner:

Patient Name:				
Prescribed Treatment Product/ Services	**Reason for Treatment/ Medical Condition**	**Instructions/ Restrictions (if applicable)**	**Date of Diagnosis/Onset**	**Duration/No. of Treatments**

I hereby certify that the treatment plan(s) listed above is medically necessary to treat the ailment or medical condition listed above. This treatment plan is neither for cosmetics or general health and well-being.

_____

Medical Practitioner's Printed Name

_____ _____

Medical Practitioner's Signature **Date**