HealthPartners®

Letter of Medical Necessity

(For use with HRA and FSA spending accounts)

Employee information (please print)

Patient Name | Employer Name

Employee Name | Employee SSN

This form should be completed by the medical practitioner to confirm treatment is necessary for a specific medical condition. This information is strictly confidential and will be used only for the purposes of processing claims. ***The form must be submitted every plan year.*** Complete the following:

Diagnosis: _____

CPT Code(s): _____

Specific recommended treatment: _____

_____

_____

Start date of treatment: ____/____/____

End date of treatment: ____/____/____

Certification

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health and is not for cosmetic purposes to improve appearance.

Signature of Medical Practitioner | ***Date***

Print Name

Address | Phone

Mail this form to: **HealthPartners Service Center**
CDHP - Mail Route 21104T
P.O. Box 297
Minneapolis, MN 55440-0297

Or Fax to: **952-883-5026, 1-877-624-2287**

Questions: **Metro Area: 952-883-7000**
Outside metro: 1-866-443-9352
TTY line: 952-883-5127
healthpartners.com

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Letter of Medical Necessity Instructions

According to the Internal Revenue Service (IRS), some healthcare services and products are only eligible for reimbursement from your healthcare Flexible Spending Account (FSA) or Limited-Use FSA when your doctor or provider certifies that they are medically necessary.

HealthPartners has developed this form to assist you and your healthcare provider in providing the information we need to process your claim. Your provider must indicate:

- Your (or your spouse's or dependent's) specific diagnosis
- The specific treatment needed
- The start and end dates of treatment
- Certification that the treatment is medically necessary

Your provider can also submit a statement on his or her letterhead, as long as the letter includes **all** of the information on this form, including the certification of medical necessity.

By submitting the Letter of Medical Necessity, you certify that the expenses you are claiming are a direct result of the medical condition described, and you would not incur the expenses if you were not treating this medical condition.

You only need to submit this form with the first claim you submit for the service or product. If the treatment extends beyond the time period listed, you must submit a new Letter of Medical Necessity covering the new time period.

You must submit a new letter of medical necessity each plan year — they cannot be approved indefinitely.

Submitting this form does not guarantee that the expense will be reimbursed.

Your provider can use the following guidelines when completing a letter of medical necessity:

- The diagnosis must be specific. For example, a diagnosis of "elevated levels of triglycerides or cholesterol" is not specific. A diagnosis of "hypercholesterolemia" is specific.
- The recommended treatment must be named and described in detail by your licensed healthcare provider. A recommended treatment described as "regular or daily exercise recommended for weight loss" is not enough information. Your provider must specifically name and describe the recommended treatment. An acceptable description of treatment would be "I recommend an exercise program through a gym membership for the next 6 months to alleviate the patient's hypertension."
- Your provider must state a specific treatment period (with clear start and end dates). Lifetime or indefinite lengths of treatment will not be approved.
- Your licensed provider must complete, sign and date the form.