Certificate of Medical Necessity

Employer Name: ____________________

Participant Name (First, MI, Last): ____________________

Social Security Number: ______ - ______ - __________

Address: ____________________

City, ST, ZIP: ____________________

Date of Birth: ________/________/________ Phone Number (______) ____________

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your FSA/HRA Account when your doctor or other licensed health care provider certifies that they are medically necessary for a specific medical condition. Your provider must fully complete this Certification to render the services eligible.

VITAMINS/SUPPLEMENTS: Only reimbursable when a specific medical condition is identified ("Vitamin Deficiency" does not qualify; "Iron Deficiency" qualifies)

WEIGHT LOSS: Meal replacement, protein shakes and powders are NOT eligible for reimbursement per the IRS rules

You must submit a copy of this Certification prior to submitting your first Reimbursement Request Form for this specific service or product. If treatment extends beyond the time period listed, you will need to submit a new Certification detailing the new time period.

By submitting this form to Lifetime Benefit Solutions, you certify that this information is true and correct.

Medical Information—*Please print clearly*

Patient's Name: ____________________

Relationship to Participant: ____________________

Specific Medical Condition/Diagnosis: ____________________

Recommended treatment/services/products: ____________________

Describe how the treatment/service/product will alleviate the diagnosis or symptoms:

____

Durations or recommended treatment/services/products: ____________ through ____________

Or other duration: ____________________

Provider Information

Provider Name: ____________________ Phone Number: (______)____________

Provider Signature: ____________________ Date: ____________

- **Mail to:** Lifetime Benefit Solutions, Claims Dept, PO Box 6509, Syracuse, NY 13217 or **Fax to:** 877-256-7228.
- Call **Customer Service** with questions at 800-327-7130.
- I authorize the above expenses to be reimbursed from my dependent care account.
- I certify the expenses qualify as valid dependent care expenses under the terms of the PII understand that the copy of my receipt will include Provider name, address, tax ID/SSN, child's name and age, dates of care, and amount charged.
- I will keep copies of all documents submitted to Lifetime Benefit Solutions, for my own personal records; Lifetime Benefit Solutions, is not responsible for retaining copies of my receipts beyond the current Plan year.