The Federal FSA Program

Letter of Medical Necessity (LMN)

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA) when your doctor or other licensed health care provider certifies that they are medically necessary. **Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.**

FSAFEDS has developed this letter to assist you and your health care provider in providing the information we need in order to process your claim. 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.

By submitting this LMN you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition. If you are claiming membership to a health club, you must certify that you were not already a member of a health club.

You only need to submit this form, or your provider's letter containing the same information, with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new LMN each year – they cannot be approved indefinitely. Submitting this form does not guarantee that the expense will be reimbursed.

Note: All fields below are required.

Date:	Email Address:
Account Holder's Name:	Account Holder's UserID/SSN:
Patient's Name:	
Diagnosis:	CPT Code:
Recommended Treatment:	
How will the treatment alleviate the diagnosis?	
Begin Date of Treatment:	End Date of Treatment: (not to exceed 12 months)
Provider Signature:	
Provider Name:	
Provider Address:	
Provider License #:	Provider Telephone #:

If you have questions you may visit the FSAFEDS web site at www.FSAFEDS.com or contact an FSAFEDS Benefits Counselor, toll-free, at 1-877-FSAFEDS (372-3337), TTY: 1-800-952-0450, Monday through Friday, 9:00 A.M. until 9:00 P.M., Eastern Time. **You may fax this claim form to 1-866-643-2245 (toll-free) or 1-502-267-2233.**

Note: FSAFEDS' role is to make sure that the proper documentation is submitted for reimbursement under the Plan. FSAFEDS will review this letter of medical necessity for completeness and to ensure that the treatment meets IRS guidelines and FSAFEDS eligibility standards.