

**Flexible Spending Account Letter of Medical Necessity**

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) 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, and how this treatment will alleviate your medical condition.

ASIFlex 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.

*The letter will be valid for expenses incurred for one year from the date on the letter. At the end of one year, a new letter will be required.*

[Date]	
[Employee Name]	[SSN/EID]
[Patient Name]	
[Diagnosis]	[CPT Code]
Dear ASIFlex:	
Please describe what the recommended treatment is, how that treatment will alleviate the diagnosis or symptoms, and the duration of the treatment required.	
Sincerely,	
[Provider Signature]	
[Provider Name]	
[Provider License # & State]	
[Provider Telephone #]	

If you have questions you may visit the ASIFlex’s website at [www.asiflex.com](http://www.asiflex.com) or contact an ASIFlex benefits counselor at 1-800-659-3035, Monday through Friday, 7 A.M. to 7 P.M. Central Time, or Saturday, 9 A.M. to 1 P.M. Central Time.

*Note: ASIFlex’s role is to ensure that the proper documentation is submitted for reimbursement under your Flexible Spending Account plan, and not to determine whether the treatment prescribed by your health provider is medically necessary. ASIFlex will review this letter of medical necessity for completeness only.*