



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 (HCFSAs) or Limited Expense Health Care Flexible Spending Account (LEX HCFSAs) 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 the treatment, and how this treatment will alleviate your medical condition.

EBS/Atlanta 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 Letter of Medical Necessity 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 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, once for the current Plan Year. 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 Letter of Medical Necessity each year - they cannot be approved indefinitely. Submitting this form or your provider's letter does not guarantee that the expense will be reimbursed.

DATE		EMAIL ADDRESS	
YOUR NAME		SSN	
PATIENT NAME		RELATION TO YOU	
DIAGNOSIS		CPT CODE	

[Recommended Treatment]
[How will the treatment alleviate the diagnosis?]
[Length of Treatment Required]
Provider Signature
[Provider Name]
[Provider Address]
[Provider License Number]
[Provider Telephone Number]

If you have questions, please contact EBS/Atlanta toll-free at 1-800-647-3709 Monday through Friday, 8:30 a.m. until 5:00 p.m., Eastern Time, or by email to flex@ebsatlanta.com. You may fax this form or your provider's letter to 1-770-569-0211 or mail to EBS/Atlanta, 2500 Northwinds Parkway, Suite 400, Alpharetta, Georgia 30004.

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

INSTRUCTIONS FOR SUBMITTING YOUR LETTER OF MEDICAL NECESSITY

IMPORTANT: When you submit a Letter of Medical Necessity you must include detailed information or we cannot approve your request.

Please use the following guidelines when submitting 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 health care 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 a monitored exercise program through a gym membership for the next 6 months to alleviate the patient’s hypertension”.
- Your provider must state a specific length of treatment (not to exceed 12 months). Lifetime or indefinite lengths of treatment will not be approved.
- Your licensed provider must complete, sign and date the form.