Letter of Medical Necessity Form

administered by CHARDSNYDER

COMPANY INFORMATION (please print)

Company Name

PARTICIPANT INFORMATION (please print)

Last Name		Primary Phone ( ) -
First Name		Secondary Phone ( ) -
SSN	Date of Birth (mm/dd/yyyy) / /	Email Address

If the letter of medical necessity is required for claims for a spouse or eligible dependent, please provide the following information:

PATIENT NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH
		/ /

MEDICAL NECESSITY (to be completed by your medical provider)

DIAGNOSIS:	**CPT CODE:**
RECOMMENDED TREATMENT:	
EXPLAIN HOW THIS TREATMENT WILL ALLEVIATE THE DIAGNOSIS OR SYMPTOMS OF THE MEDICAL CONDITION:	
DATE RANGE OF TREATMENT	From / / through / /

PROVIDER INFORMATION AND CERTIFICATION

Provider Name		
Provider Phone	License #	State

By signing below, I certify that this service or product is medically necessary to treat the specific medical condition described above and is not for general good health or cosmetic purposes.

Provider's Signature:	**Date** / /

PARTICIPANT CERTIFICATION

By signing below, I certify that the following sections Medical Necessity and Provider Information and Certification were completed by the above treating physician. The expense I am claiming is not for general good health or cosmetic purposes. The expense is due to the direct result of the medical condition as described above and would not have been incurred but to treat the medical condition as recommended by the healthcare provider. I also understand that this letter of medical necessity does not guarantee that the expense will be reimbursed under my plan.

Participant Signature (Required)	**Date** / /

SEND THIS FORM TO CHARD SNYDER

Please send the completed form with the signature of the healthcare provider and participant to Chard Snyder using one of the following:

☑ **Fax to:** Local (513) 459-9947 / Toll-free (888) 245-8452
(Please DO NOT include a fax cover page)
☑ **Mail to:** 6867 Cintas Boulevard, Mason, OH 45040
☑ **Email to:** 53askpenny@chard-snyder.com

Letter of Medical Necessity Instructions

Under Internal Revenue Service rules, some health care services and products are only eligible for reimbursement from your Healthcare Flexible Spending Account (FSA) when your doctor or other licensed health care provider certifies that they are medically necessary. The expense also would not have been incurred but for the direct result of treating the specific diagnosed medical condition. **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.**

This form is to assist you and your health care provider to submit 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. (This form is not used for reimbursement of over-the-counter medications. Those items require a doctor's prescription.)

For fast and accurate processing of your reimbursement request, please make sure to include this letter of medical necessity form or your provider's letter and itemized receipts or other documentation. If you are claiming membership to a health club, you must not already be a member of a health club and will need to submit documentation showing the membership was obtained after your healthcare provider's recommendation. The reimbursement request claim form can be found at 53hsa.com. Please be sure to print the requested information clearly on all documentation submitted.

Please note: *If your treatment extends beyond the time period listed by the provider, you will need to submit a new doctor's statement form upon expiration of the initial treatment dates. The maximum time period provided on the form cannot exceed one year from the date of the doctor's signature. If treatment extends beyond one year, a new form will be required at the end of each one-year period.*

Fax, mail or email this form and supporting documentation directly to **Chard Snyder**:

- ☑ **Fax to:** Local (513) 459-9947 / Toll-Free (888) 245-8452
  (*Please DO NOT include a Fax Cover Page*)
- ☑ **Mail to:** 6867 Cintas Boulevard, Mason, OH 45040
- ☑ **Email to:** 53askpenny@chard-snyder.com

If you have questions, please contact us:

- ☑ Call Customer Service: (888) 350-5353
- ☑ Visit our website: www.53hsa.com
- ☑ Email your questions to: 53askpenny@chard-snyder.com

Submission of this form is not a guarantee that the expense will be reimbursed.