PAYFLEX®

Letter of Medical Necessity

Fax or Email completed form and documentation to: Fax: 1-844-306-8146
Email: PayFlex_Receipts@alegeus.com

Your account can reimburse you for an expense that is for eligible medical care. Some services and products may be for both general good health and to treat a medical condition. For these, PayFlex may ask for a Letter of Medical Necessity (LOMN). With a LOMN, a health care provider confirms the specific diagnosis, the specific treatment needed and how this expense is needed to treat this medical condition. Some examples of services needing a LOMN are massage therapy and exercise.

This form can help you send the information we need to process your claim. Your health care provider can complete and sign this form. Or, he or she may write the same information on the health care provider's letterhead.

If you will have more than one claim for the same service or product, you will only need to submit the LOMN with the first claim. However, if the treatment goes beyond the treatment period, you must submit a new LOMN for the new treatment period. If you have an ongoing condition, you will have to submit a new LOMN every twelve months, since it is good one year from the date written. This is because treatment plans may change over time. **Note**: The LOMN is not a guarantee that you will receive reimbursement for the expense. If we do not receive the LOMN, we will deny the claim.

PLEASE PRINT CLEARLY

Section A - Member / Patient Information (To be completed by Member)

Patient First Name	**MI**	**Last Name**	
Member First Name	**MI**	**Last Name**	**Member Social Security Number** *(Last 4 Digits)*
Employer Name			
I certify that the expense is for the medical condition described below. I am only incurring the expense to treat this medical condition. If this is for membership to a health club, I certify that I was not already a member of any health club.			
Member Signature ✍			**Date** (MM/DD/YYYY)

Section B - Treatment Recommendation (To be completed by Health Care Provider)

Describe the diagnosed medical condition being treated or provide a statement that a medical condition is being treated.	**Diagnosis Code(s)**
Recommended Treatment (Include any service, treatment or product used to treat the condition. If using more than one, list everything related to this claim.)	**CPT Code(s)**
Begin Date of Treatment (MM/DD/YYYY)	**End Date of Treatment** (MM/DD/YYYY) (if less than 1 year from begin date)
Provider Name	

Provider Street Address	**City**	**State**	**Zip Code**
I certify that this service or product is medically necessary. It is to treat the specific medical condition described above. It is not for general good health or cosmetic reasons. If the treatment is a food or a form of food or drink, I certify the treatment is **not** a general diet product and **does not** satisfy normal nutritional needs.			
Provider Signature ✍			**Date** (MM/DD/YYYY)

Note: PayFlex's role is to ensure proper documentation for reimbursement under the Plan. We will review this letter of medical necessity for completeness only and to determine if the treatment meets IRS guidelines.

Mail this form to: PayFlex Systems USA, Inc, HSA Operations, PO Box 3615, Carol Stream, IL 60132-3615