Alight Smart-Choice Accounts
Statement of Medical Necessity

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from a health care account when your doctor or other licensed health care provider certifies that they are medically necessary. This form can assist you and your health care provider in providing this information. As an alternative, your provider may also write a letter or prescription, as long as it includes all requirements outlined below.

Dual-purpose items

When a health care service or product can be used for both medical and general health reasons, it is referred to as "dual purpose." For these items, you must provide additional information to confirm the expense is medically necessary.

Examples of items requiring a Statement of Medical Necessity

- Modifications to automobile
- Braille books
- Cosmetic surgery
- Dental implants
- Exercise equipment
- Humidifiers
- Lodging
- Massage therapy
- Mattresses
- Prescribed food
- Sunglasses
- Support hose
- Tutoring
- Umbilical cord storage
- Vacuums
- Weight loss
- Wigs

A complete listing of eligible expenses and documentation requirements can be found on the web site. All items requiring additional documentation, including dual-purpose items, can be identified by a "○ " on the list of eligible expenses.

Requirements

The Statement of Medical Necessity was created to capture all information needed to prove a product or service is medically necessary.

The following information is required:

- Patient name
- Specific diagnosis, diagnosis code (ICD-9), or medical condition
- Specific length of treatment (including a begin and end date)
- Name of particular product or service being prescribed
- Medical provider's signature
- Date (must be in the current calendar year)
- Statement that the product or service is medically necessary and not for general health or cosmetic purposes

If you choose to have your provider write a letter, it must be on the provider's letterhead and include the information provided above.

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Account holder information

___________________________ _____________ _____________________________________
First name MI Last name

(_____) _______ | ___________ ___________________________ ___________________________
Daytime phone number Employee ID (optional) Employer

Instructions

To have your claim approved, you must submit 1) this completed form, 2) a claim form, and 3) a detailed receipt or Explanation of Benefits (EOB) from your medical insurance provider. Once received, your claim will typically be processed within ten days.

Send your claim to:

Fax: 855-673-6719 OR Mail: Alight Smart-Choice Accounts
PO Box 64009
The Woodlands, TX 77387-4009

If faxing, be sure to place the claim form before your itemized receipts and Statement of Medical Necessity.

To be completed by a licensed practitioner

___________________________________ ____
Patient name Diagnosis, diagnosis code (ICD-9), or specific medical condition

__________ / __________ / __________ to _________ / _________ / _________
Length of recommended treatment (MM/DD/YYYY)—may not extend beyond the current plan year or 12 months, whichever is less; “to present” and “indefinitely” will not be accepted, as they are not definitive dates

____
Specific product or service used to treat diagnosis—please list each item separately

*The purpose of this form is to confirm the proper documentation is submitted for reimbursement consideration under the plan and is not to determine whether the treatment prescribed by your health provider is medically necessary. The form will be reviewed for completeness only.

Licensed practitioner certification

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By my signature below, I certify that this service or product is medically necessary to treat the medical condition described above and is not in any way for general health or cosmetic purposes.

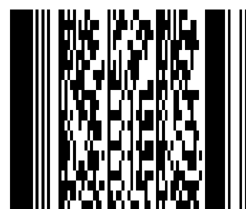
Provider signature ____________________ Date ____________

Employee certification

By my signature below, I certify that:

- The primary reason for this expense is to treat the medical condition above, and
- I would not incur this expense but for the medical condition.

Employee signature ____________________ Date ____________



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