

## Letter of Medical Necessity

The Internal Revenue Service requires a doctor's statement be provided for certain health care expenses in order to be reimbursed from your TexFlex health care flexible spending account (FSA). The doctor's statement must indicate the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

This form will assist you and your health care provider in providing the information we need in order to process your reimbursement request. Your provider can also write a letter on his or her letterhead, as long as the letter includes all the information on this form.

In addition to the information from your provider, certain expenses require a "but for" statement from the employee noting that the expense would not have been purchased had it not been for the provider's recommended treatment plan. A "but for" certification section is also included in the form, which should be completed by you to ensure all required information is on file.

For fast and accurate processing of your reimbursement request, please make sure to include this doctor's statement form or your provider's letter and the employee "but for" statement along with an itemized receipt or other documentation. The reimbursement request claim form can be found on the self-service employee web site provided by your employer. 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.*

**Send the completed form with the signature of the health care provider and participant to:**

**FAX:**

TexFlex FSA  
1-866-643-2219 Toll-free

**MAIL:**

ADP TexFlex  
P.O. Box 34700  
Louisville, KY 40232

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

*(continued)*

Please print clearly with blue or black ink or type. Signature sections must be signed.

<b>Employee name</b>	
<b>Alternate ID/SSN</b>	
<b>E-mail</b>	
<b>Phone</b>	
<b>Employer</b>	
<b>Patient name</b>	
<b>Diagnosis/Diagnosis code</b>	
<b>CPT code</b>	
<b>Recommended treatment (must be explained in detail)</b>	
<b>How will the recommended treatment alleviate the diagnosis or symptoms?</b>	
<b>Date treatment began</b>	
<b>How long is the treatment required?</b>	
<b>Additional comments</b>	
<b>Provider name and title</b>	
<b>Provider address</b>	
<b>Provider phone</b>	
<b>Provider license # and state</b>	
<b>Provider signature</b>	
<b>Date</b>	
<b>Employee certification</b>	By signing below, I certify that this expense would not have been incurred "but for" the recommendation of the health care provider.
<b>Employee signature</b>	
<b>Employee printed name</b>	
<b>Date</b>	