



Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Care Flexible Spending Account (HCFSA) when your doctor or other licensed health care provider certifies that they are medically necessary.

FlexSave has developed this letter to assist you and your health care provider in providing the information we need in order to process your claim.

By submitting this LMN you certify that the expenses you are claiming are a direct result of the medical condition(s) 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 submission form, or your provider's letter containing the same information, with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period.

Recommended Treatment/Medication	Specific Medical Condition it's treating or diagnosis code	Start Date	End Date

Patients Name: _____

Physicians Name (please print): _____

Signature: _____

By signing this form, I certify that the recommended treatment, medication, or product is for treating a specific medical condition and is in no way for general health or cosmetic purposes.

Name of Practice: _____

Address: _____

Phone: _____