Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Medical Flexible Spending Account (FSA) when your doctor or other licensed health care provider certifies that they are medically necessary. In order for those services or products to be certified as medically necessary, a Letter of Medical Necessity (LMN) must be provided by your doctor or other licensed health care provider. **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 being provided to assist you and your health care provider in providing the information we need in order to process your claim. Completing the information requested below and sending it to us with your first claim will act as a LMN. If your provider prefers, he can also submit a statement on his or her letterhead, as long as the letter includes **all** of the information on this form.

By submitting this LMN you certify that the expenses you are claiming are a direct result of the medical condition 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 must certify that you were not already a member of a health club.

You only need to submit this 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. You must submit a new LMN each year – they cannot be approved indefinitely. Submitting this form does not guarantee that the expense will be reimbursed.

Date_____

Employee Name_____

Patient Name_____

Diagnosis_____

Recommended Treatment or Specific Name of Product _____

_____

_____

Begin Date of Treatment_____

End Date of Treatment _____(not to exceed 12 months)

Provider Signature _____

Provider Name_____

Provider Address_____

Provider Phone Number #_____

If you have questions you may contact SIEBA, LTD at the numbers listed below.

SIEBA, LTD. is providing this sample letter to ensure proper documentation is submitted with your incurred expense in order for it to be considered eligible for reimbursement under your Medical Flexible Spending Account.

SIEBA, LTD. 111 Grant Ave, Suite 202, PO Box 5000, Endicott, NY 13761-5000
(607) 786-3003 * (800) 252-4624 * (607) 786-3378 FAX