MAIL TO:
PayFlex Systems USA, Inc.
Flex Dept.
P.O. Box 3039
Omaha, NE 68103-3039
Toll Free (866) 887-3539
Toll Free (866) UTS- FLEX

LETTER OF MEDICAL NECESSITY

FAX TO:
PayFlex Systems USA, Inc.
Flex Dept.
(877) 230-4283
(No Cover Page Required)
Page 1 of _____

Must be completed by the PayFlex Participant:

Patient Name: _____

Participant Name: _____

Participant's Employer: _____

Member Number: _____

(This is your Benefits ID or employer assigned number)

Expenses must be medically necessary in order to qualify for reimbursement. Since some healthcare services and products such as massage therapy and weight loss programs may be for both medical and non-medical reasons, PayFlex may request your Physician to confirm that an expense is recommended for treatment AND is a direct result of a specific diagnosed medical condition.

If requested, this form may be completed and signed by your physician (OR) your physician may submit the same information on signed letterhead stationery. You must attach the Letter of Medical Necessity form or letter to your claim form or to our request for the medical information. Upon receipt, your account will be noted.

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition. Complete the following:

1. Describe the diagnosed medical condition being treated. (Include diagnosis code):

_____

_____

_____

2. Describe the recommended treatment:

_____

_____

_____

3. Indicate the duration of treatment:

_____

_____

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health; and is not for cosmetic purposes to improve appearance.

_____ _____

Signature of Attending Physician ***Date***

_____

Print Name (First & Last)

Address: _____ **Phone:** (_____) _____ - _____

_____

Rev. 7/2008