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. Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, and how this treatment will alleviate your medical condition.

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. Your provider 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 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.

[Date]	[Email Address]
[Employee Name]	[Last Four Digits of SSN]
[Patient Name]	
[Diagnosis]	[CPT Code]
Dear FlexSave:	
Please describe what the recommended treatment is, how that treatment will alleviate the diagnosis or symptoms, and the duration of the treatment required.	

Sincerely,

Provider Signature	
[Provider Name]	
[Provider License # and State]	[Provider Telephone #]