Health Reimbursement Arrangement (HRA)
Flexible Spending Account (FSA)

Statement of Medical Necessity Form

To properly verify medical expenses you have submitted for reimbursement, we must obtain authorization from the licensed healthcare provider administering your treatment.

Please print.

TO BE COMPLETED BY PARTICIPANT	
Participant Name:	SSN:
Employer Name:	
Email:	
Patient Name:	Patient Date of Birth:

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER	
Name:	Office Phone:
Office Name:	
Treatment Period (include start and stop date):	Diagnosis Code:
Describe Required Treatment:	

Signature of Licensed Healthcare Provider

I hereby certify that the treatment administered for the above patient is required and medically necessary, and not for general health or cosmetic purposes.

_____ _____

Signature **Date**

Participant Authorization

I am substantiating my request for payment from my Health Reimbursement Arrangement or my Flexible Spending Account for the expenses listed above. To the best of my knowledge, my statements on this form are true and complete. I take full responsibility for the accuracy of all information I have provided.

_____ _____

Signature **Date**

Please email, mail or fax your completed form to:
MidAmerica Administrative & Retirement Solutions, Attn: HRA/FSA Dept.
P.O. Box 24927, Lakeland, FL 33802
Phone: 855-329-0095
Fax: 863-577-4460
Email: claims@myMidAmerica.com

Tip: When completing your HRA/FSA Claim Form, please make sure to note that you have this Medical Necessity Form on file with us.