Print Form Clear Form

MidAmerica

HRA/FSA Statement of Medical Necessity Form

Return this completed form to:
MidAmerica Administrative & Retirement Solutions
PO Box 24927, Lakeland, FL 33802
Ph: (855) 329-0095

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

STEP 1 TO BE COMPLETED BY PARTICIPANT

Participant Name

Social Security Number

Employer Name

Email Address

Patient Name (Must be participant, spouse, or an eligible dependent)

Date of Birth (MM/DD/YYYY)

STEP 2 TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

Name

Office Phone

Office Name

Health Care Provider's Specialty

Treatment Period (*include start and stop date)

Diagnosis Code

Describe Required Treatment

*If no stop date is provided, this form will be valid for one year.

Signature of Licensed Health Care 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. I certify that all expenses for which reimbursement or payment is claimed were incurred either by me, my spouse, or my eligible dependent(s). 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: _____