



HRA/FSA Statement of Medical Necessity Form

Return this completed form to:
U.S. BENCOR/MidAmerica
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

<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>
Participant Name		Social Security Number
<input type="text"/>		
Employer Name		
<input type="text"/>		
Email Address		
<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>
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

<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>
Name		Office Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>
Office Name	Health Care Provider's Specialty	
<input type="text"/>	<input type="text"/>	
Treatment Period (*include start and stop date)	Diagnosis Code	
<input type="text"/>	<input type="text"/>	
Describe Required Treatment		
<input type="text"/>		
<input type="text"/>		

*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: _____