Certificate of Medical Necessity

Employer Name: _____

Participant Name (First, MI, Last): _____

Social Security Number: _____ - _____ - _____

Address: _____

City, ST, ZIP: _____

Date of Birth: _____/_____/_____ Phone Number (_____) _____

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your FSA/HRA Account when your doctor or other licensed health care provider certifies that they are medically necessary for a specific medical condition. Your provider must fully complete this Certification to render the services eligible.

VITAMINS/SUPPLEMENTS: Only reimbursable when a specific medical condition is identified ("Vitamin Deficiency" does not qualify; "Iron Deficiency" qualifies)

WEIGHT LOSS: Meal replacement, protein shakes and powders are NOT eligible for reimbursement per the IRS rules

You must submit a copy of this Certification prior to submitting your first Reimbursement Request Form for this specific service or product. If treatment extends beyond the time period listed, you will need to submit a new Certification detailing the new time period.

By submitting this form to Lifetime Benefit Solutions, you certify that this information is true and correct.

Medical Information– *Please Print Clearly* ***All Fields Must be Completed***

Patient's Name: _____

Relationship to Participant: _____

Specific Medical Condition/Diagnosis: _____

Recommended treatment/services/products: _____

Describe how the treatment/service/product will alleviate the diagnosis or symptoms:

_____

Durations or recommended treatment/services/products: _____ through _____

Or other duration: _____

Any claims for dates of service outside of the duration indicated above will not be eligible for reimbursement

Provider Information

Provider Name: _____ Phone Number: (_____)_____

Provider Signature: _____ Date: _____

- **Mail to:** Lifetime Benefit Solutions, Claims Dept, PO Box 680 Liverpool, NY 13088 or **Fax to:** 877-256-7228.
- Call **Customer Service** with questions at 800-327-7130.
- I authorize the above expenses to be reimbursed from my dependent care account.
- I certify the expenses qualify as valid dependent care expenses under the terms of the PII understand that the copy of my receipt will include Provider name, address, tax ID/SSN, child's name and age, dates of care, and amount charged.
- I will keep copies of all documents submitted to Lifetime Benefit Solutions, for my own personal records; Lifetime Benefit Solutions, is not responsible for retaining copies of my receipts beyond the current Plan year.