

LETTER OF MEDICAL NECESSITY

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Spending Account when your doctor, or other licensed health care provider, certifies that they are medically necessary. **Your provider must indicate the patient's specific diagnosis, the specific treatment needed, and how this treatment will alleviate the medical condition.** Be sure to send this letter of medical necessity in with your completed claim form.

You may use 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 their letterhead, as long as the letter includes **all** of the information on this form.

To ensure fast and accurate processing of your reimbursement request, you only need to submit this provider form, or your provider's letter containing the same information, with the first claim you submit for the service or product. If the treatment extends beyond the time period listed, you must submit a new form or physician letter covering the new time period. If a time period is not stated, the letter of medical necessity will be valid for one year. **Please note, treatments that are considered to be solely for general well being, or are personal care items, are not reimbursable under Code 213(d).** For a more complete list, visit our website at www.selectaccount.com.

Member Name	
SelectAccount ID/Social Security Number	
Address	
Phone Number	
Patient Name	
Diagnosis/Medical Condition	
Recommended Treatment CPT Code/Service/Product	
What is the treatment time period?	
Provider Name License # and State	
Provider Address	
Provider Telephone #	
<i>I certify that this treatment is medically necessary.</i> Provider Signature	
Date	

If you have questions you may contact SelectAccount Customer Service at 651-662-5056 or 1-800-859-2144.

Note: SelectAccount's role is to ensure that the proper documentation is submitted for reimbursement under the Plan, and not to determine whether the treatment prescribed by your doctor or other licensed health care provider is medically necessary.

RETURN THIS FORM WITH A COMPLETED CLAIM FORM TO:

SelectAccount
P.O. Box 64193
St. Paul, MN 55164-0193
Fax (651) 662-7247 / 1-866-231-0214

FORMS AVAILABLE:
www.selectaccount.com
or by calling
SelectAccount Customer Service

CUSTOMER SERVICE:
(651) 662-5065
(800) 859-2144