LETTER OF MEDICAL NECESSITY

Under Internal Revenue Service rules, some health care services and products are only eligible for reimbursement from your health care FSA, limited purpose health care FSA, or health reimbursement arrangement (HRA) when your licensed health care provider (provider) certifies that they are medically necessary. The expense also would not have been incurred but for the direct result of treating the specific diagnosed medical condition. **Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.**

Paylocity has developed this form to assist you and your provider in providing the information we need in order to process your claim. Your provider can also submit a statement on his or her letterhead as long as the letter includes **all** of the information on this form. This form is not used for reimbursement of over-the-counter medications. Those items require a doctor's prescription. **Keep a copy of the completed form for your records. The completed form must be submitted with each claim for the same expense.**

PARTICIPANT INFORMATION

Full Name:		Participant Address:			
Company:					
Phone:		Date of Birth:		Last 4 of SSN:	
If the letter of medical necessity is required for claims for your spouse or eligible dependent, please provide the following information:					
Patient Name:		Relationship to Employee:		Date of Birth:	

MEDICAL NECESSITY (TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER)

Diagnosis:		CPT Code:	$
Recommended Treatment:			
Explain how this treatment will alleviate the diagnosis or symptoms of the medical condition:			
Date range of treatment:	From	Through	

HEALTH CARE PROVIDER INFORMATION AND CERTIFICATION

Provider Name:					
Provider Phone:		License #:		State:	

By signing below, I certify that this service or product is medically necessary to treat the specific medical condition described above and is not for general good health or cosmetic purposes.

Licensed Health Care Provider's Signature (required): _____ Date: _____

PARTICIPANT CERTIFICATION

By signing below, I certify that the previous Medical Necessity and Provider Information and Certification sections were completed by the above treating health care provider. The expense I am claiming is not for general good health or cosmetic purposes. The expense is due to the direct result of the medical condition as described above and would not have been incurred but to treat the medical condition as recommended by the health care provider. I also understand that this letter of medical necessity does not guarantee that the expense will be reimbursed under my plan.

Participant Signature (required): _____ Date: _____

Submit this form, the corresponding claim form, and receipts electronically through the Employee Portal, via our mobile app, or send to Paylocity: Secure Email: batinfo@paylocity.com • Fax: 314-909-6983 • Mail: PO Box 7410394 Chicago, IL 60674-0394

Please note: If your treatment extends beyond the time period listed by the provider, you will need to submit a new letter of medical necessity form upon expiration of the initial treatment dates. The maximum time period provided on the form cannot exceed one year from the date of the provider's signature. If treatment extends beyond one year, a new form will be required at the end of each one-year period.

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