Letter of Medical Necessity

Use this form to request reimbursement for health care products and services that require authorization from a medical practitioner to be considered eligible for reimbursement from a Medical Spending Account (MSA).

INSTRUCTIONS

1) Complete the form on Page 2.
    a. Complete **Section I** (including your signature and the date) *prior* to visiting your medical practitioner.
    b. Bring the form with you to your next medical appointment and request that the attending medical practitioner complete **Section II**. Instruct them to follow the specific pharmacy/prescription laws in their respective state when completing Section II.
2) Submit a copy of this completed form to TASC with each reimbursement request (if submitting online, include a copy with your receipts). Any *Letter of Medical Necessity* received without a reimbursement request will not be processed.
3) A *Letter of Medical Necessity* is effective for 12 months from the date signed by the medical practitioner, or until the end of the benefit plan year in which it was submitted. You must submit a new form each plan year in which you request reimbursement, or any time the treatment plan changes.

DEFINITIONS

- *"Letter of Medical Necessity"* refers to any order for health care products or services signed by a licensed medical practitioner granted prescriptive authority by the laws of the state. It contains the name and quantity of the medicine/product/service prescribed, directions for use and treatment duration.
- "Medical practitioner" generally includes the following licensed health professionals: physician (MD/DO), physician assistant, nurse practitioner, dentist, optometrist and podiatrist.

Products and services that require a *Letter of Medical Necessity* or other medical practitioner authorization to show the expense is to treat a medical condition include the following:

- Air purifier
- Automobile modifications
- Ear plugs
- Exercise equipment
- Massage therapy
- Nutritionist's professional fees
- Orthopedic shoes (excess cost only)
- Special foods (excess cost only)
- Support hose
- Varicose vein treatment
- Whirlpool/spa
- Wigs

The information contained in this communication is confidential and to be used by TASC employees and representatives for only its intended purpose.
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Letter of Medical Necessity

Submit this completed form with your reimbursement request either online or via fax or mail.	Fax	Mail
	608.663.2762	TASC, P.O. Box 7308 Madison, WI 53704-7308

SECTION I – PARTICIPANT AUTHORIZATION

Employer Name:		Employer ID:	
Individual First Name:		Last Name:	
TASC ID:		Email Address:	
Primary Phone:		Mobile Phone:	

The statements in this document are complete and true to the best of my knowledge and belief. I understand that the IRS regulates my MoneyPlus account(s) and that the guidelines are implemented as a means of ensuring compliance with reimbursable expenses and that TASC reserves the right to verify the eligibility of the expenses in accordance with IRS regulations. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests.

_____ _____

Participant's Signature Date

SECTION II – TREATMENT INFORMATION

To be completed by medical practitioner.

Patient Name:				
Prescribed Treatment Product/Services	**Reason for Treatment/ Medical Condition**	**Instructions/Restrictions (if applicable)**	**Date of Diagnosis/Onset**	**Duration/No. of Treatments**

I hereby certify that the treatment plan(s) listed above is medically necessary to treat the ailment or medical condition listed above. This treatment plan is neither for cosmetics or general health and well-being.

_____ _____

Medical Practitioner's Signature Date

_____

Medical Practitioner's Printed Name

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