

Letter of Medical Necessity



To be reimbursable through your Plan, some healthcare reimbursement requests require additional information. **Effective 1/1/2011, this includes Over-The-Counter (OTC) expenses that fall under the category of "medicines and drugs" (with the exclusion of insulin).**

A prescription or Letter of Medical Necessity must be submitted for such expenses. A new prescription or Letter must be submitted each Plan Year in which you request reimbursement of prescribed items or services, or any time the treatment plan changes.

For each individual in your household for whom you purchase healthcare expenses, complete Section I of this form; the attending physician should complete Sections II and III. **Submit the completed form(s) to TASC with each Request for Reimbursement.** (If more space is required please complete another form.)

SECTION 1

Participant Name (Last, First, M) (PLEASE PRINT) _____ 12-Digit TASC ID Number _____

Participant Employer/Company Name (PLEASE PRINT) _____ Participant Signature/Date _____

The statements on this document are complete and true, to the best of my knowledge and belief. I understand that the IRS regulates my flex plan account and that the guidelines are implemented as a means of ensuring compliance. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests.

SECTION II

Patient's Name: _____

Prescribed Medicine/Product: _____

Reason for Treatment: _____

Instructions/Restrictions (if applicable): _____

Patient's Name: _____

Prescribed Medicine/Product: _____

Reason for Treatment: _____

Instructions/Restrictions (if applicable): _____

Patient's Name: _____

Prescribed Medicine/Product: _____

Reason for Treatment: _____

Instructions/Restrictions (if applicable): _____

Patient's Name: _____

Prescribed Medicine/Product: _____

Reason for Treatment: _____

Instructions/Restrictions (if applicable): _____

SECTION III

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 cosmetic reasons nor for general health and well-being.

Medical Practitioner Name (PLEASE PRINT) _____ Date _____/_____/_____

Medical Practitioner Signature _____

- If you reside in Indiana, Michigan, Montana, Pennsylvania or South Dakota you may be required to meet additional requirements to meet State pharmacy laws.
- Participants should retain a copy of this completed form for their records.

Submit a copy of the completed form(s) to TASC with each Request for Reimbursement (if submitting online, include a copy with your receipts and Veriflex Cover Sheet). A Letter of Medical Necessity received without the appropriate form will be not be processed and will need to be resubmitted for reimbursement.