Flexible Benefits System, Inc.

AN ALERA GROUP COMPANY

CERTIFICATE OF MEDICAL NECESSITY

1-800-622-6233
Questions | Assistance

PART1-EMPLOYEE SECTION

Employer Name		
Participant's Name	Date of Birth	Last 4-Social Security #

PART 2-Medical

This form completed by your Provider is required upon request and at a minimum annually.

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 this Certificate PRIOR to submission of your first Reimbursement Request Form for this specific treatment, service or product. If treatment extends beyond the time period listed, a new Certification is required, outlining the new time period

Patient's Name	Relationship to Participant
Specific medical condition or diagnosis	
Recommended treatment/services/products	
Describe how the treatment, service, &/or product will alleviate the diagnosis or symptoms	
Duration or recommendation treatment/services/products	Date: _____through date _____ Or other duration _____

Provider Printed Name		Provider Signature
Provider Phone	Date	Provider's NYS ID#

Your signature below and submission of this form Flexible Benefits System, Inc., certifies that this information is true and correct.

Participant Signature	Date

Mail to: Flexible Benefits System, Inc.
400 WillowBrook Office Park-Suite 400
Fairport NY 14450
800-622-6233

Or Fax 585-641-7500
Or Email customerservice@fbsflex.com
Use your phone camera to attach form to email

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