



LETTER OF MEDICAL NECESSITY

Use this form to be reimbursed for healthcare products and services that require authorization from a Medical Practitioner to be considered eligible for reimbursement from a Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA) or other BASIC benefit account.

INSTRUCTIONS

- 1) Complete the form on the following page:
 - a. Complete **Section I** (including your signature and the date) *prior* to visiting your Medical Practitioner.
 - b. Bring this 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) You must submit a copy of this completed form to BASIC with each Request for Reimbursement (if submitting online, include a copy with your receipts). Any Letter of Medical Necessity received without a Request for Reimbursement will not be processed.
- 3) The Letter of Medical Necessity will be considered 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. A new form must be submitted each plan year in which you request reimbursement, or any time the treatment plan changes.

DEFINITIONS *(for the purposes of this form)*

- “Letter of Medical Necessity” refers to any order for healthcare 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	Exercise Equipment	Orthopedic Shoes (excess cost only)
Varicose Vein Treatment	Automobile Modifications	Massage Therapy
Special Foods (excess cost only)	Whirlpool/Spa	Ear Plugs
Nutritionist's Professional Fees	Support Hose	Wigs



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Include this completed form with your Request for Reimbursement online, or submit via fax or mail:	Fax	Mail
	(269) 327-0716	BASIC, PO Box 6278 Monona, WI 53716

SECTION I – PARTICIPANT AUTHORIZATION

Employer Name:		Employer ID:		
First Name:		MI:		Last Name:
Benefits ID (12-digit):		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 benefit account(s) and that the guidelines are implemented as a means of ensuring compliance with reimbursable expenses and that BASIC 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 Printed Name

Medical Practitioner's Signature

Date