DAKOTACARE®

2600 West 49th Street
Sioux Falls, SD 57105-6575 *FLEX*

Phone: 1-800-325-5598
Fax: 1-605-336-0270
Email: flex@dakotacare.com

FLEXIBLE SPENDING ACCOUNT
LETTER OF MEDICAL NECESSITY

Patient Name: _____

Employee Name: _____

Employee SSN/DKC Insurance ID: _____

Employer Name: _____

1. List diagnosed medical condition (include diagnosis code):

_____

_____

_____

_____

2. List recommended service/equipment for condition:

_____

_____

_____

_____

3. Duration of time service/equipment for condition is needed:

_____

_____

_____

_____

_____ _____

Signature of Attending Physician *Date*

_____

Print Physician Name

Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Attach a copy of this form (after being completed by your physician) when submitting for reimbursement of services and equipment listed above from your Flexible Spending Account.