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 Code: __________

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.***