Letter of Medical Necessity form

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Processing may be delayed if fields with an asterisk are not filled out.

Filled out by the participant

Your licensed practitioner must complete a letter of medical necessity (LOMN) for any medical service or product that is categorized as a potentially eligible or ineligible expense in the Internal Revenue Code (IRC). The letter of medical necessity must show why an otherwise potentially eligible or ineligible expense is needed to treat your or your eligible dependent's medical condition. BenefitHelp Solutions provides a list of common medical expenses at **benefithelpsolutions.com/pdfs/fsa_expenses.pdf**.

Patient name

* Patient name	* Participant name
* Participant employer	* SSN or BHS Identification number

I certify that the expenses related to this letter of medical necessity are a direct result of the medical condition described below, and I would not incur the expense if it were not for treating the medical condition.

* Participant's signature X	* Signature date

Please submit this form prior to or with the first claim filed for the specified services or products. Your letter of medical necessity will only apply to expenses incurred between the treatment start and end dates. It will expire one year after the date of your provider's signature. Submitting this form does not guarantee your expense will be reimbursed. BHS will reimburse your expense only if Internal Revenue Service (IRS) guidance permits us to do so.

Filled out by licensed practitioner

* Diagnosis code or medical condition	* CPT code
* Describe recommended treatment, including how the treatment will alleviate or cure the above condition.	
* Treatment start date (MM/DD/YY) _____ /_____ / _____	* Treatment end date (not to exceed 12 months) (MM/DD/YY) _____ /_____ / _____

I certify that the recommended treatment is medically necessary to treat the specific medical condition listed above and will not be used in any way for general health or cosmetic purposes.

* Print name of licensed practitioner	* Provider license number	* Provider telephone number
* Licensed practitioner's signature X		* Signature date

Ready to submit? Mail, fax, email, or submit this form online to BenefitHelp Solutions.

Mail: BenefitHelp Solutions, P.O. Box 67230, Portland OR 97268

Fax: 888-249-5058 **Email:** Claims@benefithelpsolutions.com **Online:** benefithelpsolutions.com

Questions? Contact BenefitHelp Solutions at 888-398-8057.