

## ► Certificate of Medical Necessity

Employer Name: \_\_\_\_\_

Participant Name (First, MI, Last): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City, ST, ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

**Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.**

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 a copy of this Certification prior to submitting your first Reimbursement Request Form for this specific service or product. If treatment extends beyond the time period listed, you will need to submit a new Certification detailing the new time period.*

By submitting this form to Lifetime Benefit Solutions, you certify that this information is true and correct.

### Medical Information— Please Print Clearly

### All Fields Must be Completed

Patient's Name: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Specific Medical Condition/Diagnosis: \_\_\_\_\_

Recommended treatment/services/products: \_\_\_\_\_

Describe how the treatment/service/product will alleviate the diagnosis or symptoms:

\_\_\_\_\_

Durations or recommended treatment/services/products: \_\_\_\_\_ through \_\_\_\_\_

Or other duration: \_\_\_\_\_

**\*Any claims for dates of service outside of the duration indicated above will not be eligible for reimbursement\***

### Provider Information

Provider Name: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- **Mail to:** Lifetime Benefit Solutions, Claims Dept, PO Box 680 Liverpool, NY 13088 or **Facsimile:** 877-256-7228.
- Call **Customer Service** with questions at 800-327-7130.

• I authorize the above expenses to be reimbursed from my dependent care account.

• I certify the expenses qualify as valid dependent care expenses under the terms of the PII understand that the copy of my receipt will include Provider name, address, tax ID/SSN, child's name and age, dates of care, and amount charged.

• I will keep copies of all documents submitted to Lifetime Benefit Solutions, for my own personal records; Lifetime Benefit Solutions, is not responsible for retaining copies of my receipts beyond the current Plan year.

