Ensure that the most current form is submitted. Refer to EMACS Forms/Procedures website.

FLEXIBLE SPENDING ACCOUNT (FSA) PLAN
LETTER OF MEDICAL NECESSITY

Must print in Black or Blue ink ONLY.

Employee ID	Rcd No.	Last Name, First Name	
Email Address		Department	Phone Number

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Flexible Spending Account (FSA) when your licensed medical physician certifies that they are medically necessary. The purpose of this form is to obtain verification from your physician that such service(s) and/or products meet medical necessity as defined by IRC Section 213. The Letter of Medical Necessity (LMN) is valid for the period of time established by your physician or up to one year, dependent on which comes first. If the treatment extends beyond the time period listed or beyond one year, you must submit a new LMN. Submitting this LMN form does not guarantee that the expense(s) will be reimbursed.

Date	Patient Last Name, First Name	Phone Number
Recommended Treatment (frequency and dosage)		
Duration of Treatment		

I certify the healthcare service(s) and/or products stated above is a direct result of a medical condition and is medically necessary to cure, mitigate, treat, or prevent a disease and will be primarily used to alleviate or prevent a physical or mental defect or illness. I certify that the information stated above is a direct result of a disease rather than to promote general health.

Date	Provider Name	Phone Number
Provider Address		
Provider Signature		**License No.**

Employee Certification

I certify the healthcare service(s) and/or products stated above are a direct result of a medical condition and are medically necessary to cure, mitigate, treat, or prevent a disease and will be primarily used to alleviate or prevent a physical or mental defect or illness. I certify that the information stated above is a direct result of a disease rather than to promote my general health and that I would not have incurred the expense if stated medical condition was not present. For example, if you are claiming expenses for membership to a health club, you certify that you were not already a member of a health club. By requesting completion of this form, I authorize my physician to release my protected health care information to San Bernardino County's Medical Expense Reimbursement Plan Administrator.

Employee Signature	Date

HR-EBSD Office Use Only

Reviewed by	Date	Approved/Denied	Keyed By	Date
		☐ Approved ☐ Denied		