CHARDSNYDER™
Benefit Solutions

Letter of Medical Necessity Form

COMPANY INFORMATION

State of Florida

PARTICIPANT INFORMATION (PLEASE PRINT)

Last Name	Primary Phone ( ) -
First Name	Secondary Phone ( ) -
People First ID	Date of Birth (mm/dd/yyyy) / /

If the letter of medical necessity is required for claims for your spouse or eligible dependent, please provide the following information:

PATIENT NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH
		/ /

MEDICAL NECESSITY (TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER)

DIAGNOSIS:	**CPT CODE:**
RECOMMENDED TREATMENT:	
EXPLAIN HOW THIS TREATMENT WILL ALLEVIATE THE DIAGNOSIS OR SYMPTOMS OF THE MEDICAL CONDITION:	
DATE RANGE OF TREATMENT	From / / through / /

HEALTH CARE PROVIDER INFORMATION AND CERTIFICATION

Provider Name		
Provider Phone	License #	State

By signing below, I certify that this service or product is medically necessary to treat the specific medical condition described above and is not for general good health or cosmetic purposes.

Licensed Health Care Provider's Signature:	**Date** / /

PARTICIPANT CERTIFICATION

By signing below, I certify that the previous Medical Necessity and Provider Information and Certification sections were completed by the above treating health care provider. The expense I am claiming is not for general good health or cosmetic purposes. The expense is due to the direct result of the medical condition as described above and would not have been incurred but to treat the medical condition as recommended by the health care provider. I also understand that this letter of medical necessity does not guarantee that the expense will be reimbursed under my plan.

Participant Signature (required)	**Date** / /

SEND THIS FORM TO CHARD SNYDER

Send the completed form with the signature of the health care provider and participant to Chard Snyder using one of the following:

☑ **Fax:** 888.245.8452 **(Please DO NOT include a fax cover page.)**
☑ **Mail:** 6867 Cintas Boulevard, Mason, OH 45040

Letter of Medical Necessity Instructions

Under Internal Revenue Service rules, some health care services and products are only eligible for reimbursement from your health care FSA when your licensed health care provider (provider) certifies that they are medically necessary. The expense also would not have been incurred but for the direct result of treating the specific diagnosed medical condition. **Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.**

Chard Snyder has developed this form to assist you and your provider in providing the information we need in order to process your claim. Your provider can also submit a statement on his or her letterhead as long as the letter includes **all** of the information on this form. (This form is not used for reimbursement of over-the-counter medications. Those items require a doctor's prescription.)

For fast and accurate processing of your reimbursement request, please make sure to include this letter of medical necessity form or your provider's letter and itemized receipts or other documentation. If you are claiming membership to a health club, you must not already be a member of a health club and will need to submit documentation showing the membership was obtained after your provider's recommendation. The reimbursement request claim form can be found on the Chard Snyder website. Please be sure to print the requested information clearly on all documentation submitted.

Please note: *If your treatment extends beyond the time period listed by the provider, you will need to submit a new letter of medical necessity form upon expiration of the initial treatment dates. The maximum time period provided on the form cannot exceed one year from the date of the provider's signature. If treatment extends beyond one year, a new form will be required at the end of each one-year period.*

Fax or mail this form and supporting documentation directly to Chard Snyder:

- ☑ **Fax:** 888.245.8452 **(Please DO NOT include a fax cover page.)**
- ☑ **Mail:** 6867 Cintas Boulevard, Mason, OH 45040

If you have questions please contact us:

- ☑ **Call Customer Service:** 855.824.9284
- ☑ **Visit our Website:** PeopleFirst.MyFlorida.com
- ☑ **Email your questions:** FloridaAskPenny@chard-snyder.com For security reasons, please do not send claims or personal information through email

Submission of this form is not a guarantee that the expense will be reimbursed.