Letter of Medical Necessity
Pre-Tax Benefit Plans

Employee Information

Employer Name

Employee Name

Social Security Number

Instructions: Information Below to Be Filled Out by Licensed Healthcare Provider

The individual listed above has requested reimbursement of a medical related expense from their pre-tax benefit plan for the patient listed below. This medical expense would be ineligible for reimbursement, absent a specific physician's order or prescription. Each of the following elements is needed to verify that the expense is not simply for the patient's general wellbeing or general health but rather is necessary for the treatment of a specific medical condition.

Attestation of Medical Necessity

☐ I am a licensed healthcare provider, and I attest that this patient is currently under my care for the condition described below.

Patient Name: ____________________

Specific Medical Diagnosis: ____________________

Service/Product Prescribed: ____________________

Necessity of Service/Product: Please describe the medical necessity of the prescribed service or product.

Duration of Treatment: Maximum duration for Letter of Medical Necessity is 12 months from the signature date. In some rare cases, the duration may not have an end date (for instance braille reading materials.)

☐ Less than 12 months (describe below) ☐ 12 months ☐ Request ongoing (rare circumstances; describe below)

Provider Information

Provider Name and License:

Email:

Mailing Address:

Phone Number:

Provider Signature

I have prescribed the above referenced service/product for the treatment of the patient for the specific medical condition identified above. I certify that this service or product is medically necessary to treat the specific medical condition listed and is not being prescribed for general health or cosmetic purposes.

Date: **Provider Signature:**

© 2025 Vita Administration Company