Clear Form

Letter of Medical Necessity

Your medical care provider must provide a prescription or a Letter of Medical Necessity for a service or purchase that falls under the category of "ineligible expense" in IRC section 213 (d)(1) if your provider believes the service or purchase is medically necessary to treat, cure, or mitigate a disease or condition for you or your federal tax dependent(s). IMPORTANT NOTICE: **(Effective January 1, 2011)** A prescription that satisfies state requirements must accompany any reimbursement request for an over-the-counter medicine or drug, except Insulin. **(Use of this form will not meet this requirement.)** You may obtain a list of eligible and ineligible expenses at www.goigoe.com. Please allow up to 4 business days for your completed request to be updated online.

INSTRUCTIONS: INCLUDE RECEIPTS AND DOCUMENTATION WITH THIS REQUEST FORM

1. **Complete** all applicable sections of this form.
2. **Ask your Provider** to complete sections B and C of this form.
3. **Attach a** completed Flexible Benefit Plan Reimbursement Request Form and follow the submittal instructions outlined in the "INSTRUCTIONS" section of that document. **Remember to keep original receipts for your records as you may be required to provide documentation directly to the IRS in the event of a personal audit.** All supporting documentation becomes a part of your request and will not be returned to you.
4. **Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You *(All information is REQUIRED. Please print clearly)

Clear Section A

Employer Name

Participant Name	Number of pages	Employee Number (If Applicable)	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: About The Expense *(All information is REQUIRED. Please print clearly)

Clear Section B

Patient Name	Provider Name	
Relationship to the Participant	Illness/Condition Being Treated	Expiration Date of the Recommendation

Recommended Product

Section C: Provider Acknowledgement *REQUIRED (PLEASE SIGN AND DATE)

I hereby acknowledge that the above listed services meet the requirements of IRC Section 213 (d)(1), that is that medical care was provided to diagnose, cure, mitigate, treat, or prevent a disease or for the purpose of affecting any structure or function of the body. I further acknowledge that the Patient Name, Provider Name, Relationship to the Participant, Illness/Condition Being Treated, Expiration Date of the Recommendation, Recommended Product as listed above are correct.

Provider's Signature: Ready To Sign? Click To Print ***Date:*** _____

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