

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). 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. **If you are unable to attach your form or document to an online or mobile app claim or alert**, you may use one of these secondary options to send your documentation to us. Please note, that Igoe cannot guarantee the security of any documentation provided to use via the below methods while in transit to our organization:
 - Email to flex@goigoe.com
 - Fax to 800-456-9083
 - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
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)**

Employer Name

Participant Name	Number of pages	Employee Number (If Applicable)	
Home Address <input type="checkbox"/> 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)**

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: _____ **Date:** _____

