



**VitaFlex
Medical Reimbursement Plan
Statement of Medical Necessity**

Employee Data

| | |
|-------------------------------------|--|
| Employer Name | |
| Employee Name | |
| Social Security Number or ID Number | |

Description of Need for Information

The participant listed above has requested reimbursement of a medical related expense that would be determined ineligible for his or her Flexible Benefits plan without a specific physician's order or prescription. The following information is needed to verify that the expense is not simply for the claimant's general well being or general health, but necessary for the treatment of a specific ailment.

Patient Information

| | |
|--------------------------|--|
| Patient Name | |
| Relationship to Employee | |

Medical Provider Information

| | |
|-----------------|--|
| Provider Name | |
| Street Address | |
| City, State ZIP | |
| Phone Number | |

Treatment Plan/Statement of Medical Necessity

Please describe the medical necessity of the proposed treatment plan and any requirement for special medical services or devices.

Specific Medical Diagnosis: _____

Service/Equipment Prescribed: _____

Proposed Treatment Start Date: _____

Proposed Treatment End Date: _____

Provider Signature

I have prescribed the above referenced services/equipment for the treatment of the patient identified above. I certify to the medical necessity of the treatment plan outlined.

| | |
|--|--|
| | |
|--|--|

Date

Provider Signature