Letter of Medical Necessity (LMN)

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Care Flexible Spending Account (HCFSA) or other designated Eligible Pre Tax Accounts when your doctor or other licensed health care provider certifies that they are medically necessary. 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.

125Company has provided this letter to assist you and your health care 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. By submitting this LMN you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition.

- If you are claiming membership to a health club, you must certify that you were not already a member of a health club. Initiation fees do not apply.

You only need to submit this form, or your provider's letter containing the same information, with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new LMN each plan year – they cannot be approved indefinitely.

Submitting this form does not guarantee that the expense will be reimbursed.

Date: _____ Email Address: _____

Account Holder's Name: _____

Account Holder's User ID/last four of SSN: _____

Account Holder's Employer: _____

Patient's Name: _____

Diagnosis: CPT Code: _____

Recommended Treatment: _____

_____

How will the treatment alleviate the diagnosis? _____

Begin Date of Treatment: _____ End Date of Treatment: _____ (not to exceed 12 months or remaining current plan year)

Provider Signature: _____

Provider Name: _____

Provider Address: _____

Provider License # (if available): _____ Provider Telephone #: _____

If you have questions you may visit www.`125Company.com or email us at Support@125Company.com

Our consumer support is at 877-303-3539 -- or fax at 877-303-0742

Note: 125Company's role is to make sure that the proper documentation is submitted for reimbursement under your employer's plan.