



FSA LETTER OF MEDICAL NECESSITY
Fax to 518-641-0325
Any questions please call 866-989-8995

Under IRS rules, certain Flexible Spending Account (FSA) expenses are eligible for reimbursement only when accompanied by a Letter of Medical Necessity.		
Patient Name:		Prescriber Name:
Patient DOB:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Prescriber Address:
Patient Address:		Prescriber Telephone Number:
Section A - Must be completed by Prescriber		
Please check the class of OTC medication below that you have deemed medically necessary to treat the condition(s) of your patient. By doing so, you are enabling your patient to purchase these medicines with FSA funds on a pre-tax basis.		
<input type="checkbox"/> Acid Controllers	<input type="checkbox"/> Cold Sore Remedies	<input type="checkbox"/> Respiratory Treatments
<input type="checkbox"/> Allergy & Sinus	<input type="checkbox"/> Cough, Cold & Flu	<input type="checkbox"/> Sleep Aids & Sedatives
<input type="checkbox"/> Antibiotic Products	<input type="checkbox"/> Digestive Aids	<input type="checkbox"/> Stomach Remedies
<input type="checkbox"/> Anti-Diarrheal	<input type="checkbox"/> Feminine Anti-Fungal/ Anti Itch	<input type="checkbox"/> Other (Please Specify)
<input type="checkbox"/> Anti-Gas	<input type="checkbox"/> Hemorrhoidal Preps	_____
<input type="checkbox"/> Anti-Itch & Insect Bite	<input type="checkbox"/> Laxatives	_____
<input type="checkbox"/> Anti-parasitic Treatments	<input type="checkbox"/> Motion Sickness	_____
<input type="checkbox"/> Baby Rash	<input type="checkbox"/> Pain Relief	
<input type="checkbox"/> Ointments/Creams		
Section B - Prescriber Signature		
<i>I certify that the information I have completed in the certificate is true to the best of my knowledge. I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.</i>		
Prescriber' Signature:		Date:

Member should submit this form with first claim submitted. This letter will be valid for expenses incurred for one year from date of letter. At that time new letter will be required.

The Preferred Group
PO Box 15136
Albany NY, 12212
Fax 518-641-0325

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