FSA Letter of medical necessity Mail or

fax completed forms to:

Address: **Sentinel Benefits & Financial Group**
100 Quannapowitt Pkwy Suite 300
Wakefield MA 01880

Fax: 781.213.7301

Sentinel Benefits & FINANCIAL GROUP

For faster processing, enter the claim and upload required documentation using the File a Claim option on your consumer portal

Letter of medical necessity

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your health care FSA, limited purpose FSA, and HRA when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must indicate your (or your qualified dependent's) specific diagnosed medical condition, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.

Sentinel Benefits has developed this letter to assist you and your health care provider in providing the information needed 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** the required information on this form.

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 letter of medical necessity each year—services cannot be approved indefinitely. Submitting this form does not guarantee that you will be reimbursed for the expense.

Account holder information

Company name	Last 4 of SSN		
Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	Work phone ( )	

Patient information

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition.

Patient name	Diagnosis/Treatment (please print)

Describe the diagnosed medical condition being treated:

_____

_____

Describe the recommended treatment (Must be specific. If recommending supplements, herbs, or exercise equipment, list specific name(s) and itemize). Reimbursements will be made according to listed items only.

_____

_____

How will the treatment alleviate the diagnosed condition?_____

Treatment time period (not to exceed 12 months): Start date_____/_____/_____ to End date_____/_____/_____

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health and is not for cosmetic purposes to improve appearance.

Physician name (please print)		Signature of physician
Provider license number (optional)	Date	Provider phone number
Provider address		