



LETTER OF MEDICAL NECESSITY

PARTICIPANT INFORMATION <i>(to be completed by participant)</i>			
Participant Name:			
Employer Name:			
Employee Number/ID:			
TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER			
Patient Name	Prescribed Treatment Product/Services	Reason for Treatment	Instructions/Restrictions (if applicable)
I hereby certify that the treatment plan(s) listed above is medically necessary to treat the ailment or medical condition listed above. This treatment plan is neither for cosmetic reasons nor for general health and well-being.			
Medical Practitioner's Name (PLEASE PRINT)			
Medical Practitioner's Signature			Date

The statements on this document are complete and true, to the best of my knowledge and belief. I understand that the IRS regulates my employee benefits account and that the guidelines are implemented as a means of ensuring compliance. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests.

Signature of Plan Participant

Date

**When filling out your TASC Claim Form, please be sure to note that you have this Medical Necessity Form on file with us.
Please note: TASC reserves the right to verify the eligibility of the expense in accordance with IRS regulations.**

TASC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-316-2408.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

Please fax or mail completed forms to:

Total Administrative Services Corp (TASC) • PO Box 7511 • Madison, WI 53707-7511
Phone: 844-786-3947 • Fax: 877-231-1287

SW-5530-101016