LETTER OF MEDICAL NECSSITY

To be reimbursable through your plan, some healthcare reimbursement requests require additional information. A prescription or Letter of Medical Necessity must be submitted for such expenses. A new prescription or letter must be submitted each plan year in which you request reimbursement of prescribed items or services, or any time the treatment plan changes. For everyone in your household for whom you purchase healthcare expenses, we ask that you complete Section I of this form; the attending physician should complete Sections II and III. Submit the completed form(s) to TASC with each Request for Reimbursement. (If more space is required please complete another form.)

SECTION 1 (to be completed by benefit participant)

Participant Name	
Participant Employer	
Patient Name	
12-digit benefit ID#	

SECTION 2 (to be completed by physician)

I am currently treating _____ for the following:
(Patient's Name)

1. Treatment Plan: _____
   Start Date of Treatment: _____/_____/_____ Anticipated Last Date of Treatment: _____/_____/_____
   Medical treatment, medicines, drugs, service, procedure, equipment or supply: _____
   _____
2. Treatment Plan: _____
   Start Date of Treatment: _____/_____/_____ Anticipated Last Date of Treatment: _____/_____/_____
   Medical treatment, medicines, drugs, service, procedure, equipment or supply: _____
   _____
3. Treatment Plan_____
   Start Date of Treatment: _____/_____/_____ Anticipated Last Date of Treatment: _____/_____/_____
   Medical treatment, medicines, drugs, service, procedure, equipment or supply: _____
   _____

SECTION 3

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.

_____ _____/_____/_____
Physician Name (PLEASE PRINT) Date

_____
Physician Signature