



PRESCRIPTION ORDER FORM

INSTRUCTIONS

- 1) Use this form to be reimbursed for healthcare products and services that require physician authorization such as Massage Therapy and Exercise Equipment.
- 2) Complete the form on the following page:
 - a. Complete **Section I** (including your signature and the date) and **Section II** (Patient Name, Treatment Prescribed, and Reason for Treatment) *prior* to visiting your Medical Practitioner.
 - b. Bring this form with you to your next medical appointment and request that the attending Medical Practitioner complete **Section II (Instructions/Restrictions)** and **Section III**.

Instruct them to follow the specific pharmacy/prescription laws in their respective state when completing the Instructions/Restrictions portion (Section II).
- 3) You may use the same form for each individual in your household for whom you purchase healthcare expenses, as long as the same Medical Practitioner is completing the form
- 4) TASC FSA and TASC HRA Participants must submit a copy of this completed form to TASC with each Request for Reimbursement (if submitting online, include a copy with your receipts).
 - a. Any *Prescription Order Forms* received without a Request for Reimbursement will not be processed.
 - b. AgriPlan and BizPlan participants should retain the completed form for their own records.

DEFINITIONS (for the purposes of this form)

- 1) “Medical Practitioner” generally includes the following health professionals: physician (MD/DO), physician assistant, nurse practitioner, dentist, optometrist and podiatrist.
- 2) “Prescription Order” is any order for medical services or products signed by a licensed medical practitioner granted prescriptive authority by the laws of the state. It contains the name, and quantity of the medicine/product/service prescribed, directions for use, and treatment duration.

Products and services that require a Prescription Order Form or other physician authorization to show the expense is to treat a medical condition include the following:

Air Purifier	Exercise Equipment	Orthopedic Shoes (excess cost only)
Varicose Vein Treatment	Automobile Modifications	Massage Therapy
Special Foods (excess cost only)	Whirlpool/Spa	Ear Plugs
Nutritionist’s Professional Fees	Support Hose	Wigs

***STATE RESTRICTIONS:**

The Medical Practitioner’s signature may NOT be pre-printed in the states of: Arkansas, Connecticut, Florida, Georgia, Idaho, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Virginia, and Washington.

The use of this form is prohibited; a prescription is required in: Montana, Pennsylvania, and South Dakota.



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Please complete and sign this order form per the instructions on the previous page and submit to TASC. For assistance with this form: call toll-free 855-842-4913 and have your Client ID# ready.

SECTION 1

Employer (Company) Name:	
Participant (Employee) Name:	
Participant TASC ID# (if known):	

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.

Participant's Signature

Date

SECTION 2

	Patient #1	Patient #2	Patient #3
Patient Name:			
Date of Onset: (mm/dd/yy)			
Reason for Treatment:			
Prescribed Treatment Products/Services:			
Prescribed Treatment Duration End Date:			
Instructions/Restrictions (if applicable):			

SECTION 3 - AUTHORIZATION

I hereby certify that the treatment plan(s) listed above is/are medically necessary to treat the ailment or medical condition (listed next to Reason for Treatment). This treatment plan is neither for cosmetic reasons, nor for general health and well-being.

Name of Medical Practitioner (PLEASE PRINT)

State of Prescriptive Authority

Medical Practitioner SIGNATURE

Date