PERSONALCHOICEACCOUNT

Flexible Benefits Administration

Certification of Medical Necessity

Participant Name ___________________ ID # ____________________

Company Name _______________________________

Dual-purpose items are defined as those that are generally known to be used for both a medical purpose and a personal, cosmetic or general health purpose. You may either complete this form which you can have your provider complete and sign to certify medical necessity, or you may submit a valid Letter of Medical Necessity. A new certification or letter must be sent with the first request for said item during each new plan year. If any item has a treatment time or prescription which expires, a new certification or letter will need to be sent with a new prescription. Please see our website for the definition of a valid Letter of Medical Necessity. **Any incomplete forms will be denied for completion**. A Reimbursement Request form and documentation to support the occurrence of the expense must be received as well.

I am requesting reimbursement for the Dual-Purpose Item indicated below:

Weight Loss Program

Estimated Length of Program ________

Starting Date of Care ___/____/____

Total Fee (minus any food products, cookbooks, scales, vitamins/supplements, etc not related to actual weight loss) $ ___________

Please note that we are unable to reimburse any portion of the program that extends beyond your current plan year. The remaining portion (prorated) and a new certification or Letter of Medical Necessity must be submitted each plan year while services continue.

Exercise Program (health club dues, trainer fees) / Equipment

Type of Program / Equipment _______________________

Program Commencement Date or Equipment Purchase Date ____/____/____

The Total Fee (minus any portion which is of a personal nature or is for general good health) $ __________

Initial here to certify that you were not incurring these fees before being diagnosed with the medical condition associated with your request _______

Please note that we are unable to reimburse any portion of the program that extends beyond your current plan year. The remaining portion (prorated) and a new certification or Letter of Medical Necessity must be submitted each plan year while services extend.

Supplement(s)

Name of Supplement(s) ______________________________________
Treating What Medical Condition ______________________________

Massage Therapy

Commencement of Treatment (date) ___/___/___
Length of Prescription _________________

Note that massage therapy for general good health or stress reduction is not considered eligible for reimbursement

Other Dual Purpose Items

Please Specify ____

Participant Read and Sign

I certify that I am requesting reimbursement for the services indicated above and understand that they must be medically necessary (defined as being for the prevention or alleviation of a physical or mental defect or illness). I understand that I must complete a new certification or send a new Letter of Medical Necessity with the first reimbursement of said item during each subsequent plan year. I understand that once I am no longer in need of treatment (the medical condition ceases) that these expenses will no longer be reimbursable. If for any reason, I do not complete a program or course of treatment and am refunded any portion of my total fee I will reimburse the plan, or claim the reimbursed amount on my taxes.

I further certify that I have not been, nor will I be, reimbursed by any other source for these expenses. PCA accepts no responsibility for any tax consequences associated with this reimbursement request. All other disclaimers and information on any other forms (Reimbursement Requests, Enrollment Forms) remain in affect in addition to the ones noted here.

Participant Sign ___________________________ Date ___________

Provider's Certification of Medical Necessity

Sign below to indicate that you have recommended this treatment and that you deem it medically necessary for the purpose of reimbursement under a **Flexible Spending Account** (IRS code 125).

Recommended Treatment ______________________________
Duration (or N/A) _____________________________________
Medical Condition or Diagnosis __________________________

Provider Sign ______________________ Tax ID Number _________
Date __________