

FLEXIBLE SPENDING LETTER OF MEDICAL NECESSITY

To qualify for Flexible Spending reimbursement, DMBA requires a licensed healthcare provider to confirm that healthcare expenses are recommended for treatment and are a direct result of a specific medical condition. To do this, please complete this form with your licensed healthcare provider and return it to DMBA.

PERSONAL INFORMATION (REQUIRED)

Patient name: _____ DMBA ID number: _____

Participant name: _____

Participant address: _____

Home phone: _____ Work phone: _____

LICENSED HEALTHCARE PROVIDER STATEMENT

Medical condition: _____

Recommended treatment: _____

Duration of treatment: _____

I certify the recommended treatment is medically necessary to treat the specific medical condition described above and is not solely for general good health or cosmetic reasons.

Provider name (PRINT): _____

Provider signature: _____ Date: _____

GENERAL INFORMATION

- This form will be valid for expenses incurred within one year from the date on the form. For an ongoing medical condition, a new form must be submitted annually.
- Submitting this form does not guarantee expenses are eligible for reimbursement from your Healthcare Flexible Spending Account.
- To submit this form and/or Flexible Spending claim, send it along with any necessary attachments to:

DMBA Flexible Spending
P.O. Box 45530
Salt Lake City, Utah 84145

- If you have questions about this form or expense eligibility, call DMBA or visit our website:

Salt Lake City area 801-578-5600
Toll free 800-777-3622
Fax number 801-578-5901
Website www.dmba.com

**Please return this completed form to DMBA, P.O. Box 45530, Salt Lake City, Utah 84145-0530, or fax it to 801-578-5901.
For questions, visit www.dmba.com or call us at 801-578-5600 or toll free at 800-777-3622.**