MEDICAL DETERMINATION LETTER
Flexible Spending Account

dailyaccess CORPORATION

Under IRS rules, some health care services and products are only eligible for reimbursement from your Flex Plan when your physician or other licensed health care provider certifies that the health care services or products are medically necessary. Your physician or healthcare provider must indicate your (or your dependent's) specific diagnosis, the specific treatment needed and how this treatment will alleviate your medical condition.

Please complete Section A and have Section B completed by your physician. The submission of this form does not guarantee reimbursement under the plan.

*This letter will be valid for expenses incurred during the **current Plan Year only**. A new letter may be required for reimbursements under subsequent Plan Years.*

SECTION A – To be Completed by Participant

Name of Participant: _____

Name of Patient (if different than participant)**:** _____ **Relationship:** _____

Name of Employer: _____

_____ _____

Plan Participant's Signature **Date:**

SECTION B – To be Completed by Physician

Name of Physician: _____

Address of Physician: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

Diagnosis of medical condition (include diagnostic code):

Specific description of required medical treatment including any limitations:

Expected duration of treatment:

I affirm this treatment is medically necessary to treat the specific medical condition(s) described above. This treatment is not in any way for general health, nor for cosmetic purposes.

_____ _____

Physician's Signature **Date:**

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