HealthTrust

Healthcare Flexible Spending Account (FSA)

Physician's Statement of Medical Necessity

— FOR ENROLLEE —

FSA Participant's Name: _____

Mailing Address: _____

Employer: _____

Patient's Name: _____

— FOR PHYSICIAN — ***Please complete all sections below.***

Condition Being Treated: _____

(Check and complete as appropriate)

❑ *Massage Therapy*

Frequency of Treatment: _____ per week / month / year
(insert no.)

Duration of Treatment: _____ weeks / months / years
(insert no.)

❑ *Vitamins/Supplements*

List those considered medically necessary: _____

Duration of Treatment: _____ weeks / months / years
(insert no.)

❑ *Other*

Description of Treatment: _____

Duration of Treatment: _____ weeks / months / years

I certify that the above-noted treatment is being prescribed to cure, alleviate or mitigate the medical condition listed above and that it is medically necessary. I understand that, per IRS rules, a Healthcare FSA may not be used for general health but only to treat an existing disease or condition.

_____ _____
Physician's Signature Date

_____
Print Name

_____
Practice Name

_____
Practice Address

Please email this completed statement to HealthTrust at fsa@healthtrustnh.org. Alternatively, it may be faxed to HealthTrust at 603.415.3099 or mailed to PO Box 617, Concord, NH 03302-0617.
NOTE: Submission of this form **does not** guarantee FSA reimbursement.