

Letter of Medical Necessity Form

Instructions for filling out this form:

This form is to be used when submitting requests for expenses considered to be dual-purpose.

Examples of these expenses:

- Massage therapy
- Gym memberships
- Vitamins or supplements
- Nutritionist
- Weight loss programs
- Cosmetic procedures
- Over the counter medications: allergy, cold & flu, pain relievers, etc.

The form will be kept on file, not to exceed one year. A new letter will be required if treatment is to be continued.

How do I submit this form?

Online: The fastest way to receive reimbursement for your completed claim is through the web or MyChoice® Mobile App. Reimbursement for completed claims submitted via web or mobile app is processed within 2 – 3 business days.

Via email, mail or fax: Fill out your form electronically and submit via email, mail or fax. Completed claims submitted via email, mail or fax may take up to 7 – 10 business days to process.

- **Email:** claims@mychoiceaccounts.com
- **Mail:** MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
- **Fax:** 855-883-8542

Letter of Medical Necessity Form

If filling out by hand, use only **CAPITAL LETTERS**, completely fill in and use only blue or black ink.

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SECTION 1: TO BE COMPLETED BY THE PARTICIPANT

☐ MEMBER SOCIAL SECURITY NO. or ☐ EMPLOYEE ID (Required, No Dashes)

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MEMBER LAST NAME (Required)

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MEMBER EMAIL

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEMBER DAYTIME TELEPHONE NUMBER (Area Code First, No Dashes)

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DEPENDENT SOCIAL SECURITY NUMBER

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(Required if for Dependent,
No Dashes)

COMPANY NAME

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MEMBER HOME ZIP CODE (Required)

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MEMBER DATE OF BIRTH (MM/DD/YYYY)

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☐ IS THIS A LETTER OF MEDICAL NECESSITY
FOR AN ELIGIBLE DEPENDENT?

SECTION 2: TO BE COMPLETED BY THE PROVIDER

SERVICE TYPE

RECOMMENDED SERVICE OR PRODUCT

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DIAGNOSIS

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DURATION OF TREATMENT

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CPT CODE

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DESCRIPTION OF RECOMMENDED TREATMENT

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SECTION 3: CERTIFICATION STATEMENT *Please read Certification Statement thoroughly before signing.*

This letter certifies that the expenses being claimed are due to or are a direct result of the medical condition indicated and that the expense would not be incurred other than for treatment of this medical condition. Please note, gym memberships can only be claimed if the membership is a direct result of this medical condition and that you are not already a member of a gym/fitness facility.

EMPLOYEE SIGNATURE

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DATE (MM/DD/YYYY)

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PROVIDER SIGNATURE

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DATE (MM/DD/YYYY)

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