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## Health Reimbursement Arrangement – Letter of Medical Necessity

Patient Name: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Participant's Employer: \_\_\_\_\_

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition.

1. Describe the diagnosed medical condition being treated:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Describe the recommended treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Indicate the duration of treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health and is not for cosmetic purposes to improve appearance.

\_\_\_\_\_  
Signature of Attending Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Phone Number