

Certification of Medical Necessity *Submission Form*

Some health care services and products are only eligible for reimbursement from your Health Care Flexible Spending Account (HCFSA) when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, and how this treatment will alleviate your medical condition.

Regional Care has developed this certification to assist you and your health care provider in providing the information we need in order to process your claim. Your provider can also submit a statement on his or her letterhead, as long as the letter includes **all** the information on this form.

You must submit this certification, or your provider's letter containing the same information, with each and every claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you need to submit a new certification/physician letter covering the new time period.

Employee Name:	_____
SSN:	_____
Patient Name:	_____
Diagnosis:	_____
Recommended Treatment:	_____
How will the recommended treatment alleviate the diagnosis or symptoms?	_____
How long is the treatment required?	_____
Provider Name:	_____
Provider Address:	_____
Provider Telephone #:	_____
Provider Signature:	_____
Date:	_____

If you have questions please contact Regional Care at 308-635-2260 or 800-795-7772; Regional Care Inc., 905 West 27th Street, Scottsbluff NE 69361
FAX: 308-635-2018

