

LETTER OF MEDICAL NECESSITY (LOMN)

Under Internal Revenue Service rules, some health care services and products are only eligible for reimbursement from your spending account when your doctor or eligible licensed health care provider certifies that they are medically necessary. Please use this letter to provide the information needed to process your claim. Your provider must indicate the patient's diagnosis, the recommended treatment needed, and how this treatment will alleviate the medical condition. Be sure to send this LOMN with your completed medical reimbursement form.

By submitting this LOMN, you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition. **Submitting this form does not guarantee that the expense will be reimbursed.**

You need to submit this LOMN with the first claim you submit for the service or product. If the treatment extends beyond the time period listed below, you must submit a new LOMN for the extended period. **Treatments that are considered to be solely for general well-being or are personal care items are not reimbursable under code IRC Section 213(d). For a more complete listing, visit our website at www.selectaccount.com.**

Section A – Account Holder Information – (PLEASE PRINT)

Last Name First Name Middle Initial

Street Address

City State Zip Code

SelectAccount ID or Social Security No

Daytime Phone Number:

Email Address

Section B – Diagnosis/Treatment – (PLEASE PRINT)

Patient Name: _____

Diagnosis: _____ Diagnosis Code: _____

Reason for Treatment: _____

Recommended Treatment - MUST BE SPECIFIC:

- How will the treatment alleviate the diagnosed condition?
- If recommended treatment is supplements and/or herbs or exercise equipment, list the specific name and itemize. We reimburse according to the listed items only.

Treatment time period - MUST BE SPECIFIC: ____/____/____ to ____/____/____

Section C – Provider Information – (PLEASE PRINT)

Treating Provider Name: _____

License # and Licensing State: _____

Provider Address: _____

Provider Phone Number: _____

I certify that this treatment is medically necessary to treat the diagnosed medical condition listed above.

Provider Signature

Date:

RETURN FORM TO:

SelectAccount
P.O. Box 64193
St. Paul, MN 55164-0193
Fax 651- 662-7247 / 1-866-231-0214

FORMS AVAILABLE:
www.selectaccount.com
or by calling
SelectAccount Customer Service

CUSTOMER SERVICE:
651- 662-5065
1-800- 859-2144
7 am – 7 pm, CT M-F