LETTER OF MEDICAL NECESSITY

PARTICIPANT INFORMATION *(to be completed by participant)*	
Participant Name:	
Employer Name:	
Employee Number/ID:	

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER

Patient Name	Prescribed Treatment Product/Services	Reason for Treatment	Instructions/Restrictions (if applicable)

I hereby certify that the treatment plan(s) listed above is medically necessary to treat the ailment or medical condition listed above. This treatment plan is neither for cosmetic reasons nor for general health and well-being.

Medical Practitioner's Name (PLEASE PRINT)

Medical Practitioner's Signature	Date

The statements on this document are complete and true, to the best of my knowledge and belief. I understand that the IRS regulates my employee benefits account and that the guidelines are implemented as a means of ensuring compliance. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests.

Signature of Plan Participant **Date**

When filling out your TASC Claim Form, please be sure to note that you have this Medical Necessity Form on file with us.
Please note: TASC reserves the right to verify the eligibility of the expense in accordance with IRS regulations.

Please fax or mail completed forms to:

Total Administrative Services Corp (TASC) • PO Box 7511 • Madison, WI 53707-7511
Phone: 844-786-3947 • Fax: 877-231-1287