DMBA

FLEXIBLE SPENDING
LETTER OF MEDICAL NECESSITY

##92T02113##################

To qualify for Flexible Spending reimbursement, DMBA requires a licensed healthcare provider to confirm that healthcare expenses are recommended for treatment and are a direct result of a specific medical condition. To do this, please complete this form with your licensed healthcare provider and return it to DMBA.

PERSONAL INFORMATION (REQUIRED)

Patient name: _____ DMBA ID number: _____

Participant name: _____

Participant address: _____

Home phone: _____ Work phone: _____

LICENSED HEALTHCARE PROVIDER STATEMENT

Medical condition: _____

_____

Recommended treatment: _____

_____

Duration of treatment: _____

I certify the recommended treatment is medically necessary to treat the specific medical condition described above and is not solely for general good health or cosmetic reasons.

Provider name (PRINT): _____

Provider signature: _____ Date: _____

GENERAL INFORMATION

- This form will be valid for expenses incurred within one year from the date on the form. For an ongoing medical condition, a new form must be submitted annually.
- Submitting this form does not guarantee expenses are eligible for reimbursement from your Healthcare Flexible Spending Account.

SUBMITTING YOUR CLAIM

Send this form and any necessary attachments to:

Email: DMBA_receipts@alegeus.com
Fax: 321-445-9604
Mail: DMBA Flexible Spending
P.O. Box 45530
Salt Lake City, Utah 84145

IF YOU HAVE QUESTIONS

Call DMBA at the appropriate telephone number or visit our website.

Salt Lake City area	801-578-5600
Toll free	800-777-3622
Website	www.dmba.com

Note: Submit this form only once. If you sign it electronically online, do not send a duplicate by mail, email, or fax.