Letter of Medical Necessity

PacificSource ADMINISTRATORS

PO Box 70168 ◆ Springfield, OR 97475
Phone 800.422.7038
FAX 866.446.6090
Pacificsource.com/PSA

MEDICAL INFORMATION

To be completed by provider

Patient Name: _____

Diagnoses: _____

_____

Service, program, equipment, or prescription medication being prescribed for the treatment of the above condition and/or diagnosis:*

_____

_____

***Please note:** Treatments may not be primarily for cosmetic purposes.*

Please specify the duration of treatment. If no duration of treatment is specified, this form will need to be completed for each new purchase or service:

☐ One time only

☐ 1 – 12 Months (chronic condition)
Please specify the number of months needed for treatment of the chronic condition:

_____

Provider's Signature: _____ Date: _____

Provider's Comments: _____

_____

_____

PATIENT RESPONSIBILITY

Please keep this letter for tax purposes, or for reimbursement via your flexible spending account (FSA) or health reimbursement arrangement (HRA).

To receive a reimbursement, you will need to submit a copy of this letter, a Request for Reimbursement Form, along with the appropriate verifying documentation, such as your provider's bill or your insurer's explanation of benefits (EOB) statement. Credit card receipts are not acceptable documentation.

Documentation needs to include:

- Date of service or purchase
- Charges minus any discounts or insurance payments
- Detailed description of service or purchase
- Drug name if for prescription drug purchase