# Letter of Medical Necessity (LOMN)

**Please send completed form and required documentation to National Benefit Services.**

Occasionally your doctor or licensed health care provider may prescribe specific items to treat a medical diagnosis (i.e. vitamins, supplements, etc). These items may qualify to be reimbursed through your Flexible Spending Account (FSA). To request reimbursement for these items, a Letter of Medical Necessity (LOMN) from your doctor or licensed health care provider is required.

This LOMN will be valid for the treatment period outlined below and only needs to be submitted with the first claim. If the treatment goes beyond the dates listed on this form, you must submit a new LOMN for the new treatment period. If your condition is ongoing, you will need to provide a new LOMN every 12 months. If you have a chronic condition, please make sure your health care provider notes that on this form. This will allow us to keep this LOMN on your account indefinitely.

1. Your licensed provider's information and signature is required for reimbursement
2. This form must be submitted along with a signed claim form to request reimbursement unless you are using your NBS Card for payment of services
3. Send all information to National Benefit Services using the contact information provided below

## 1 Personal Information (to be completed by participant)

Participant Name (First Name, Last Name)

Participant Social Security Number (Required)

Participant Street Address, City, State, Zip Code

Name of Person Receiving Service

Employer Name

Participant Email Address

## 2 Treatment Information (to be completed by licensed provider)

| Diagnosis/Description of Medical Condition | Diagnosis code(s) | CPT Code(s) |
|---|---|---|
| Recommended Treatment | | |
| How Long is Treatment Required? | Treatment Start Date | |

## 3 Licensed Providers Information

Provider Name

Provider License # and State

Participant Street Address, City, State, Zip Code

Provider Phone Number

I, the undersigned, attest that that this treatment information is medically necessary, and it is to treat the medical condition listed above. The treatment is not, in any way, for general health or for cosmetic reasons.

Provider Signature

Date

## 4 Participant Signature

I have reviewed the information on this LOMN and verify that the information listed above and attached is true and correct. I understand that if any changes regarding the length of treatment occur, National benefits Services must be notified immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible.

Participant Signature

Date



**Please fax, mail, or email your claim form and/or receipts to the following:**

**Mail:** National Benefit Services, LLC, P.O. Box 6980, West Jordan, UT 84084

**Fax:** (844) 438-1496

**Email:** service@nbsbenefits.com (PDF, TIFF, or JPG files only)