Letter of Medical Necessity

Participant Name: _____

Participant's Employer: _____

Participant SSN: _____

Daytime Phone Number: _____

Email: _____

This form should be completed by the attending physician to confirm treatment is medically necessary for a specific medical condition. Complete the following:

1. Diagnosis: _____ CPT Code: _____

Diagnosis: _____ CPT Code: _____

Diagnosis: _____ CPT Code: _____

2. Treatment Prescribed: _____

_____

3. Duration of treatment: _____

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health and is not for cosmetic purposes to improve appearance or relieve stress.

_____ _____

Attending Physician Signature **Date**

PLEASE PRINT:

Physician Name:	
Address:	
Telephone:	

Mail, fax or email completed form to:

McGriff Flexible Benefit Services
Flexible Reimbursement
PO Box 6400
Greenville, SC 29606

Fax: 1-252-293-9048 or 1-252-293-9049

Email: flexclaims@mcgriffinsurance.com