SHDR
STANLEY, HUNT, DUPREE & RHINE
Benefit Consultants
A division of BB&T

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:

Stanley, Hunt, DuPree & Rhine
SHDR Flexible Reimbursement
PO Box 6400
Greenville, SC 29606

Fax: 1-252-293-9048 or 1-252-293-9049
Email: shdrflexclaims@shdr.com