Progressive Benefit Solutions, LLC

FSA Medical Necessity Form

Employer Name: ____

Employee Name:	LAST	FIRST	MI		**SS#**	
Address:	STREET	CITY	STATE	ZIP	**Phone:**	( )

☐ **Please check if this is a new address**

NOTE: Information below must be completed

MEDICAL NECESSITY PHYSICIAN SUBSTANTIATION

This section must be completed by the patient's physician responsible for the diagnosis and treatment of the condition detailed below.

I am currently treating:
(PATIENT'S NAME)

I certify that the below listed prescribed treatment, service, procedure, equipment, supply and/or capital expenditure is medically necessary to treat the specific medical condition of the patient identified above and is not intended to merely preserve or promote my patient's general well-being, satisfy nutritional needs nor to serve a primary cosmetic, personal, living and/or family purpose.

IDENTIFY THE MEDICAL TREATMENT, SERVICE, PROCEDURE, EQUIPMENT, SUPPLY AND/OR CAPITAL EXPENDITURE BELOW:

PHYSICIAN NAME & LICENSE NUMBER:
(PRINT)

PHYSICIAN NAME	LICENSE NUMBER

PHYSICIAN MAILING ADDRESS:
(PRINT)

STREET	CITY	STATE	ZIP

Physician Signature: ____ **Date:** ___ /____ /_____

Employee Signature: ____ **Date:** ___ /____ /_____

KEEP THE ORIGINAL COPY FOR YOUR RECORDS, RE-SUBMIT A COPY WITH THIS CLAIM & ALL SUBSEQUENT CLAIMS FOR THIS CONDITION

FAX TO: 203-234-1139 **— OR — MAIL TO:** Progressive Benefit Solutions, LLC / 14 Business Park Drive #8, Branford CT 06405