The Health Care Flexible Spending Account Program is a division of the
Office of Labor Relations' Flexible Spending Accounts Program

Health Care Flexible Spending Account (HCFSA) Program
Medical Necessity Form

Bowling Green Station, P.O. Box 707, New York, NY 10274
Tel: (212) 306-7760 nyc.gov/fsa

HCFSA

Instructions:

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement under the HCFSA Program when your health care provider certifies that they are medically necessary. In these cases, your provider must indicate your (or your spouse's or dependent's) specific diagnosis, specific treatment recommended, the length of treatment, and how this treatment will alleviate your medical condition. Please note that medical care must be for expenses to diagnose, cure, mitigate, treat or prevent disease or to affect any structure or function of the body.

Please give this form to your health care provider so that he or she may provide the required information in order to process your claim. Your provider may also submit a statement on his or her letterhead that includes all the information requested below.

By submitting this form, you certify that the expense you are claiming is a direct result of the medical condition described below, and you would not incur the expense you are claiming if you were not treating this medical condition.

You only need to submit this form, or a letter from your health care provider, with the first claim you submit for the service or product. However, if treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new form each year; they cannot be approved indefinitely.

NOTE: **Submitting this form does not guarantee that the expense will be reimbursed. You must also submit all claims to your health insurance carrier(s) before HCFSA can process your claims.**

If you have any questions, please contact the HCFSA Program at (212) 306-7760.

PLAN YEAR: ☐☐☐☐

EMPLOYEE/PATIENT INFORMATION

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | M I | SOCIAL SECURITY NUMBER - -

PATIENT LAST NAME | PATIENT FIRST NAME | M I | RELATIONSHIP TO EMPLOYEE

EMPLOYEE SIGNATURE | DATE / /

TO BE COMPLETED BY PROVIDER ❑ I have attached a separate sheet with additional information.

PROVIDER NAME

PROVIDER ADDRESS

CITY | STATE | ZIP + FOUR +

PROVIDER LICENSE NUMBER | PROVIDER TELEPHONE NUMBER (AREA CODE) - - | PROVIDER TELEPHONE NUMBER (AREA CODE) - -

DIAGNOSIS | CPT CODE

RECOMMENDED TREATMENT

DESCRIBE HOW THE TREATMENT WILL ALLEVIATE THE MEDICAL DIAGNOSIS

LENGTH OF TIME TREATMENT REQUIRED

PROVIDER SIGNATURE | DATE: / /

OFFICE USE ONLY (DO NOT WRITE IN THIS BOX)

REVIEW DATE / /

❑ ACCEPTED
❑ DECLINED

REVIEWED BY

REASON FOR DECLINE