

# Letter of Medical Necessity



To be reimbursable through your Plan, some healthcare reimbursement requests require additional information. Effective 1/1/2011, this includes Over-The-Counter (OTC) expenses that fall under the category of “medicines and drugs” (with the exclusion of insulin).

A prescription or Letter of Medical Necessity must be submitted for such expenses. A new prescription or Letter must be submitted each Plan Year in which you request reimbursement of prescribed items or services, or any time the treatment plan changes.

For each individual in your household for whom you purchase healthcare expenses, we ask that you complete Section I of this form; the attending physician should complete Sections II and III. Submit the completed form(s) to TASC with each Request for Reimbursement. (If more space is required please complete another form.)



## SECTION 1

Participant Name (Last, First, M) (PLEASE PRINT)

12-Digit TASC ID Number

Participant’s Employer/Company Name (PLEASE PRINT)

Patient’s Name (PLEASE PRINT)

## SECTION II

I am currently treating \_\_\_\_\_ for the following:  
(Patient’s Name)

1. Treatment Plan: \_\_\_\_\_

Start Date of Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_ Anticipated Last Date of Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical treatment, medicines, drugs, service, procedure, equipment or supply: \_\_\_\_\_

2. Treatment Plan: \_\_\_\_\_

Start Date of Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_ Anticipated Last Date of Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical treatment, medicines, drugs, service, procedure, equipment or supply: \_\_\_\_\_

3. Treatment Plan: \_\_\_\_\_

Start Date of Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_ Anticipated Last Date of Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical treatment, medicines, drugs, service, procedure, equipment or supply: \_\_\_\_\_

## SECTION III

I hereby certify that the treatment plan(s) listed above is medically necessary to treat the ailment or medical condition listed above. This treatment plan is neither for cosmetic reasons nor for general health and well-being.

Physician Name (PLEASE PRINT)

Date

Physician Signature