LETTER OF MEDICAL NECESSITY

Use this form to be reimbursed for healthcare products and services that require authorization from a Medical Practitioner to be considered eligible for reimbursement from a Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA) or other ZyneraHealth benefit account.

INSTRUCTIONS

- Complete the form on the following page.
    1. Complete Section I (including your signature and the date) **prior to** visiting your Medical Practitioner.
    2. Bring this form with you to your next medical appointment and request that the attending Medical Practitioner complete Section II. Instruct them to follow the specific pharmacy / prescription laws in their respective state when completing Section II.
- You must submit a copy of this completed form to ZyneraHealth with each request for reimbursement (if submitting online, include a copy with your receipts). **Any *Letter of Medical Necessity* received without a request for reimbursement will not be processed.**
- The *Letter of Medical Necessity* will be considered effective for 12 months from the date signed by the Medical Practitioner, or until the end of the benefit plan year in which it was submitted. A new form must be submitted each plan year in which you request reimbursement, or any time the treatment plan changes.
- **Both sections of the form must be completed in full.** Incomplete forms may result in delay in processing or denial of your request for reimbursement.
- **PLEASE USE YOUR EMAIL PROVIDER'S ENCRYPTION FEATURES TO SEND YOUR EMAIL SECURELY.**

DEFINITIONS *(for purposes of this form)*

- "Letter of Medical Necessity" refers to any order for healthcare products or services signed by a licensed Medical Practitioner granted prescriptive authority by the laws of the state. It contains the name and quantity of the medicine/product/service prescribed, directions for use, and treatment duration.
- "Medical Practitioner" generally includes the following licensed health professionals: physician (MD/DO), physician assistant, nurse practitioner, dentist, optometrist, and podiatrist.

Please go www.hisd.zynerahealth.com to identify products and services that require a Letter of Medical Necessity or other Medical Practitioner authorization to show the expense is to treat a medical condition

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Include this completed form with your request for reimbursement online, or submit via fax or mail:	Fax	Mail	Email
	409-291-5064	P.O. Box 227 1708 Spring Green Blvd., Suite 120 Katy, TX 77494	claims@zynera.com

SECTION I – PARTICIPANT AUTHORIZATION

Participant Name:		Employer Name:	
Participant ID:		Email Address:	

The statements in this document are complete and true, to the best of my knowledge and belief. I understand that the IRS regulates my benefit account(s) and that the guidelines are implemented as a means of ensuring compliance with reimbursable expenses and that ZYNERAHEALTH reserves the right to verify the eligibility of the expenses in accordance with IRS regulations. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests.

Participant's Signature _____ Date _____

SECTION II – TREATMENT INFORMATION

To be completed by Medical Practitioner. All fields are required.

Patient Name:	
Relationship to Participant:	

Prescribed Treatment Product / Services	Reason for Treatment / Medical Condition	Instructions / Restrictions (if applicable)	Date of Diagnosis / Onset	Duration / No. of Treatments

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 cosmetics or general health and well-being.

Medical Practitioner's Printed Name _____

Medical Practitioner's Signature _____ Date _____