



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
nyc.gov/fsa

Please submit this form,
electronically to:
<https://nyc-fsa.leapfile.net>



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 by e-mail at nyc.gov/fsa

PLAN YEAR:

EMPLOYEE/PATIENT INFORMATION

EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	MI	SOCIAL SECURITY NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
PATIENT LAST NAME	PATIENT FIRST NAME	MI	RELATIONSHIP TO EMPLOYEE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
EMPLOYEE SIGNATURE			DATE
<input type="text"/>			<input type="text"/> / <input type="text"/> / <input type="text"/>

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	<input type="checkbox"/> ACCEPTED	REASON FOR DECLINE
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> DECLINED	<input type="text"/>
REVIEWED BY		<input type="text"/>
<input type="text"/>		<input type="text"/>