TRI-STAR SYSTEMS

# Medical Necessity Form

Some medical expenses do not qualify for a Health Care FSA unless they are prescribed by a physician to treat an existing medical condition. These items are considered "dual purpose" items since they have both a medical purpose and a personal/cosmetic or general good health purpose. Please use this form, or obtain a letter from your physician which contains this information, to document the medical necessity of your expense. Submit this form along with your claim form and supporting documentation when you file claims for this item. A new certification form from your physician is required for every new plan year.

## Participant Information (enrolled member information)

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| Participant's Name (Last, First MI): |
| Social Security Number or Account Number: |
| Employer Name: |
| Email Address: |

## Information on Medical Condition

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| Patient's Name (Last, First MI): |

*Diagnosed Medical Condition*

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*Treatment or prescription medically necessary to treat this condition, including duration.*

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## Physician Information

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| Physician Name: |
| Physician Phone: |
| Type of Medical Practice: |
| Physician's Signature & Date: |

**I hereby certify that the reimbursement requests I am submitting are considered medically necessary and are IRS eligible expenses and would not be purchased or incurred except for the medical diagnosis listed above. I also understand that Tri-Star Systems, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I understand that every new plan year will require a new form and submission for eligibility.**

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| **Participant Signature & Date:** |

***Complete & return with your claim and supporting documentation to Tri-Star.***