NueSynergy
CUSTOMER FOCUSED • TECHNOLOGY DRIVEN

Letter of Medical Necessity Claim Instructions

Health care expenses include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Expenses for solely cosmetic reasons generally are not expenses for medical care. Also, expenses that are merely beneficial to one's general health are not expenses for medical care. Because health care expenses must be for medical reasons, some expenses may require a letter from y our physician confirming the diagnosed condition, the type of treatment, why the treatment is medically necessary, and the duration of treatment. In these cases, you may be asked to provide a Letter of Medical Necessity from your attending ph ysician to substantiate your claim.

Claim submission methods: Upload or fax your completed contract to NueSynergy

- Sign In to the NueSynergy Participant Portal by going to the log-in section at www.NueSynergy.com to upload your Letter of Medical Necessity with your supporting documentation.
- Fax to: (855) 890-7238

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Participant | Letter of Medical Necessity

This Letter of Medical Necessity is used to verify that medical expenses not traditionally covered under your FSA or HRA plan, are required due to a medical condition.

PLEASE NOTE: You only need to submit this form once per plan year. Each year you are required to complete a new form.

When filling out your NueSynergy FSA/HRA Claim Form, please be sure to note that you have a Letter of Medical Necessity on file with us. Even with this form, NueSynergy still reserves the right to question the eligibility of the treatment in conjunction with IRS regulations or your plan design.

EMPLOYEE INFORMATION *(completed by you)*

Name *(First, Last)* Employer

Employee ID *(First initial, last name, last four digits of SSN)*

PATIENT INFORMATION *(completed by Primary Care Physician)*

Describe diagnosed condition to be treated:

Describe required treatment:

Indicate duration of treatment:

Clinic Name Phone

Address City State Zip

By signing below, you agree that this treatment is required, medically necessary, and not for general health purposes, or for cosmetic reasons.

Physician Signature **Date**

Printed Name