Letter of Medical Necessity

Instructions

This form is to be used when submitting requests for expenses considered to be dual-purpose.

Examples of these expenses:

- Massage therapy
- Gym memberships
- Vitamins or supplements
- Nutritionist
- Weight loss programs
- Cosmetic procedures
- Over the counter medications; allergy, cold & flu, pain relievers, etc.

The form will be kept on file, not to exceed one year. A new letter will be required if treatment is to be continued.

How Do I Submit this Form?

You can submit this form using one of the four options below:

1. Upload through the MyChoice Mobile App or your benefits portal.
2. Email this form to claims@mychoiceaccounts.com
3. Mail the form to MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
4. Fax the form to 855-883-8542

mychoice Accounts

mychoice Accounts

LETTER OF MEDICAL NECESSITY

Use only CAPITAL LETTERS, completely fill in and use only blue or black ink.

Email to: claims@mychoiceaccounts.com

SECTION 1: TO BE COMPLETED BY PARTICIPANT

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

COMPANY NAME

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

EMPLOYEE EMAIL

DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

SECTION 2: TO BE COMPLETED BY YOUR PROVIDER

SERVICE TYPE

RECOMMENDED SERVICE OR PRODUCT

DURATION OF TREATMENT

DIAGNOSIS

CPT CODE

DESCRIPTION OF RECOMMENDED TREATMENT:

SECTION 3: CERTIFICATION *Please read Certification Statement thoroughly before signing.*

This letter certifies that the expenses being claimed are due to or are a direct result of the medical condition indicated and that the expense would not be incurred other than for treatment of this medical condition. Please note, gym memberships can only be claimed if the membership is a direct result of this medical condition and that you are not already a member of a gym/fitness facility.

EMPLOYEE SIGNATURE_____ DATE (MM/DD/YY)

PROVIDER SIGNATURE_____ DATE (MM/DD/YY)