LETTER OF MEDICAL NECESSITY

FOR USE WITH AN HSA/FSA

TO BE FILLED OUT BY PARTICIPANT

PATIENT NAME

PROVIDER NAME

PROVIDER ADDRESS

TO BE FILLED OUT BY LICENSED PRACTITIONER

MEDICAL DIAGNOSIS

RECOMMENDED TREATMENT

A 45-MINUTE COMPREHENSIVE PROGRAM INCLUDING STRENGTH AND/OR AEROBIC TRAINING (IN THE FORM OF INDOOR CYCLING OR STRENGTH TRAINING) 3 TIMES WEEKLY IN ALIGNMENT WITH THE NATIONAL PHYSICAL ACTIVITY GUIDELINES

I CERTIFY THAT THIS SERVICE OR PRODUCT IS MEDICALLY NECESSARY TO TREAT THE SPECIFIC MEDICAL CONDITION DESCRIBED ABOVE AND IS NOT IN ANY WAY FOR GENERAL HEALTH OR FOR COSMETIC PURPOSES.

PRINT LICENSED PRACTITIONER NAME

SIGNATURE

DATE

A LETTER OF MEDICAL NECESSITY IS VALID FOR UP TO ONE YEAR FROM DATE OF SIGNATURE

REV'D