# LETTER OF MEDICAL NECESSITY

FOR USE WITH AN HSA/FSA/HRA

## 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*

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