Capital

An Independent Licensee of the Blue Cross Blue Shield Association

# LETTER OF MEDICAL NECESSITY (LOMN)

Under Internal Revenue Service rules, some health care services and products are only eligible for reimbursement from your spending account when your doctor or eligible licensed health care provider certifies that they are medically necessary. Please use this letter to provide the information needed to process your claim. Your provider must indicate the patient's diagnosis, the recommended treatment needed, and how this treatment will alleviate the medical condition. Be sure to send this LOMN with your completed medical reimbursement form.

By submitting this LOMN, you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition. **Submitting this form does not guarantee that the expense will be reimbursed.**

You need to submit this LOMN with the first claim you submit for the service or product. If the treatment extends beyond the time period listed below, you must submit a new LOMN for the extended period. **Treatments that are considered to be solely for general well-being or are personal care items are not reimbursable under code IRC Section 213(d). For a more complete listing, visit our website at capbluecross.com/funds**

## Section A – Account Holder Information (Please Print)

**Spending Account ID or SSN#:** _____ **Date of Birth:** _____/_____/_____

**Last Name:** _____ **First Name:** _____ **Middle Initial** _____

**Street Address:** _____

**City:**_____ **State:** _____ **Zip Code:** _____

**Primary Phone:** _____ **Email Address:** _____

## Section B – Diagnosis/Treatment (Please Print)

**Patient Name:** _____

**Diagnosis:** _____ **Diagnosis Code:** _____

**Recommended Treatment – Must be specific and legible:**

- List product, specific supplements, and/or procedure(s):
- Specify how the recommended treatment will alleviate the diagnosed condition:

_____

_____

_____

**Treatment time period – Must be specific:** _____/_____/_____ **to** _____/_____/_____

## Section C – Provider Information (Please Print)

**Treating Provider Name:** _____

**License # and Licensing State:** _____

**Provider Address:** _____

**Provider Phone Number:** _____

*I certify that this treatment is medically necessary to treat the diagnosed medical condition listed above.*

**Provider Signature:** _____ **Date:** _____

**Questions? Call Member Services at 877.293.7041.**

| **Send via secured email only:** | **Fax to:** | **Mail to:** |
|---|---|---|
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