CERTIFICATE OF MEDICAL NECESSITY

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Flexible Spending Account (FSA), Limited FSA and Health Reimbursement Arrangement (HRA) when your physician certifies that they are medically necessary.

Planned Benefit Systems, Inc. has developed this Certification of Medical Necessity (CMN) to assist you and your health care physician in supplying the information needed in order to process your claim. Your physician can also submit a statement on his or her letterhead, as long as the letter includes all of the information that is included on this form.

By submitting this CMN 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.

The Role of Planned Benefit Systems, Inc. is to ensure that the proper documentation is received in order to approve reimbursements under your employer's plan. Furthermore, PBS will review this form for completeness and determine if the recommended treatment meets the eligibility guidelines of the plan document and the IRS as defined in §213 (d).

PLEASE NOTE: THIS FORM WILL BE DENIED, WITHOUT REVIEW, IF IT IS NOT COMPLETED IN ITS ENTIRETY.

PLAN INFORMATION

EMPLOYER NAME ____ PLAN YEAR ____________________

EMPLOYEE INFORMATION

Complete this section for the primary account holder.

FIRST NAME ______________________ LAST NAME ______________________ SSN ________________

DAYTIME PHONE ____________________ EMAIL[1] ____

[1] **Email:** By providing your email address you agree to receive Employee Benefit Plan correspondence electronically. Planned Benefit Systems, Inc. does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is used solely to administer your benefit account(s). Please add our email address, help@pbs.us.com, to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your e-mail address by contacting the PBS, Inc. Customer Service Department or by visiting our website at www.pbs.us.com. Select *Tax Advantaged Plan Administration,* then *Account Information* under the Participants section. PBS, Inc. reserves the right to utilize an email address that may be provided to us by your employer.

THE NEXT TWO SECTIONS SHOULD BE COMPLETED BY YOUR LICENSED PHYSICIAN.

MEDICAL CONDITION INFORMATION

PATIENT FIRST NAME ____________________________ PATIENT LAST NAME ____________________________

DIAGNOSIS: ____ DX CODE: ________________

RECOMMENDED TREATMENT: ____
***Products and procedures must be itemized.**

DURATION OF RECOMMENDED TREATMENT: ____
***If the duration of treatment extends beyond the end of the current plan year, a new Certificate of Medical Necessity will be required for the next plan year.**

HOW WILL THE TREATMENT IMPROVE OR ELIMINATE THE DIAGNOSED MEDICAL CONDITION AND/OR THE SYMPTOMS:

____

PHYSICIAN CERTIFICATION AND INFORMATION

I certify that the recommended treatment is medically necessary and is not solely for cosmetic purpose or general good health.

PHYSICIAN SIGNATURE ____ DATE ____________________

PHYSICIAN NAME __________________________ LICENSE NUMBER AND STATE __________________________