WageWorks
formerly Planned Benefit Systems

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 practitioner certifies that they are medically necessary. WageWorks has developed this Certification of Medical Necessity (CMN) to assist you and your health care practitioner in supplying the information needed in order to process your claim. Your practitioner 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 WageWorks is to ensure that the proper documentation is received in order to approve reimbursements under your employer's plan.

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

THIS FORM WILL NOT BE ACCEPTED IN PLACE OF A DOCTOR'S PRESCRIPTION FOR THE REIMBURSEMENT OF OTC DRUGS AND MEDICINES.

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. WageWorks 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 WageWorks Customer Service Department or by visiting our website at www.pbs.us.com. WageWorks 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 PRACTITIONER.

MEDICAL CONDITION INFORMATION

PATIENT FIRST NAME ____________________ PATIENT LAST NAME ____________________

DIAGNOSIS: ____________________

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.**

PRACTITIONER CERTIFICATION AND INFORMATION

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

PRACTITIONER SIGNATURE ____________________ DATE ____________________

PRACTITIONER NAME ____________________ LICENSE NUMBER AND STATE ____________________

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