North Atlantic States
CARPENTERS BENEFIT FUNDS

Health
Benefits Fund

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HRA Reimbursement Letter of Medical Necessity

Under Internal Revenue Service rules, some health care services and products are only eligible for reimbursement from your Health Reimbursement Account (HRA) when your doctor certifies that they are medically necessary. *The fact that a provider may have prescribed, recommended, or approved a service, supply, or durable medical equipment does not in itself, make it medically necessary.*

Medically Necessary means services, supplies, or durable medical equipment that are essential for:

- essential for the treatment of the patient's condition, illness, or injury
- in accordance with standards of good medical practice
- the most appropriate level of service that can be safely provided to the patient
- not cosmetic or experimental
- not solely for comfort or convenience
- not primarily custodial

Be sure to send this Letter of Medical Necessity (LOMN) with your completed medical HRA reimbursement form. If the treatment extends beyond one year, you must submit a new LOMN. **Submitting this form does not guarantee that the expense will be reimbursed. Treatments that are considered to be solely for general well-being are not reimbursable under code IRC Section 213(d).**

Incomplete submissions of the 'Letter of Medical Necessity' will not be processed and will be returned

SECTION A: Account Holder Information (please print)

Member SSN: _____ Date of Birth (mm/dd/yy format): _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Email: _____

Member Signature: _____ **Date:** _____

SECTION B: Diagnosis / Treatment (must be completed by doctor) (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 or required treatment will alleviate the diagnosed condition:

_____

_____

Treatment time period (must be specific): Start Date: _____ **End Date:** _____

SECTION C: Provider Iformation (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:** _____