

## Letter of Medical Need

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### Why would I need to submit a Letter of Medical Need?

When you enrolled in the Health Care Spending Account (HCSAccount), you agreed to the following:

- I will only use my HCSAccount to pay for IRS-qualified expenses, permitted under the State of New York's plan, incurred by me, my spouse and my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s), before seeking reimbursement from my HCSAccount
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

WageWorks, along with the State of New York, has developed these instructions to assist you in complying with this agreement by explaining how and when to use a Letter of Medical Need.

### What expenses are eligible?

Eligible expenses include amounts for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body, and are confined strictly to those incurred primarily for the prevention or alleviation of a physical or mental defect or illness. Please refer to the NYS Flex Spending Account current plan year enrollment book for additional information on expenses eligible through the State of New York's HCSAccount plan.

### How do I seek reimbursement?

In order for incurred expenses to be reimbursed from your HCSAccount, you must follow these instructions. Only the cost of medical care and services permitted under both IRS Code § 213 and the HCSAccount plan are reimbursable. If these expenses include those services, procedures, medicines or items that can be provided for both a medical purpose and a cosmetic, personal, living and/or family purpose, as well as those involving some capital expenditures, additional substantiation must be submitted with your claim.

### What is a capital expenditure?

A capital expenditure is an item that has a useful life that extends beyond the end of the taxable year, such as an elevator, bathtub railings, etc. A capital expenditure may be reimbursed if its primary purpose is:

- to provide medical care for you as a participant, your spouse or tax dependent for an existing medical condition and
- properly substantiated as medically necessary by showing that it would not be medically necessary "but for" an existing medical condition.

A separate Capital Expenditure Worksheet is required when you submit a request for reimbursement of a capital expenditure. Refer also to the information in the NYS Flex Spending Account current plan year enrollment book and on your HCSAccount Reimbursement Request Form. For more assistance or to obtain a sample form, visit the NYS Flex Spending Account website at [www.flexspend.ny.gov](http://www.flexspend.ny.gov) or contact Customer Service at 1-800-358-7202 (option 1), 7 a.m. to 10 p.m. ET, Monday through Friday.

**Note:** If improper reimbursement of ineligible HCSAccount expenses has been made, the corrective procedures approved by the IRS and permitted under the HCSAccount plan will be followed.

### When do I need to submit a Letter of Medical Need?

A Letter of Medical Need must be submitted with your HCSAccount Reimbursement Request if the expense:

- can be provided for both a medical purpose and a cosmetic, personal, living and/or family purpose and/or
- is a capital expenditure, as previously defined.

### Letter of Medical Need Instructions:

Please **print** all information requested on the reverse of these instructions, except signatures, to ensure proper handling. At the top of the Letter of Medical Need, you must include:

- the HCSAccount participant's name
- the HCSAccount participant's NYS EMPLID
- the name of the HCSAccount participant's employer
- duration of treatment
- the patient's name and
- the patient's relationship to the HCSAccount participant.

The health care provider responsible for the patient's diagnosis and treatment of the condition specified, such as a doctor, dentist, or acupuncturist, must complete the remainder of your Letter of Medical Need before you submit it with your HCSAccount Reimbursement Request. This health care professional must be sufficiently qualified to diagnose and treat the condition for which the reimbursement is being requested. For more information, clarification or questions, contact Customer Service at 1-800-358-7202 (option 1).

**Note:** If the reimbursement request is for treatment not normally associated with the condition indicated by your health care professional in the Letter of Medical Need, additional substantiation may be required.

# Letter of Medical Need

PLEASE PRINT ALL REQUESTED INFORMATION, EXCEPT SIGNATURES, TO ENSURE PROPER HANDLING. SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS.

Participant Name: \_\_\_\_\_ Participant's NYS EMPLID: \_\_\_\_\_

Participant's Employer: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

**THIS SECTION MUST BE COMPLETED BY THE PATIENT'S HEALTH CARE PROVIDER RESPONSIBLE FOR THE DIAGNOSIS AND TREATMENT OF THE CONDITION SPECIFIED BELOW.**

I am currently treating \_\_\_\_\_  
Patient's Name

for \_\_\_\_\_  
Medical Condition

Duration of treatment is from \_\_\_\_\_

I certify that the prescribed treatment, service, procedure, equipment, supply and/or capital expenditure, listed below, is medically necessary to treat the specified medical condition (diagnosis), and is not intended to merely preserve or promote my patient's general health or well-being, satisfy nutritional needs nor primarily serve a cosmetic, personal, living and/or family purpose.

**Medical treatment, service, procedure, equipment, supply and/or capital expenditure:**

\_\_\_\_\_  
\_\_\_\_\_

Treating Health Care  
Provider Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Printed Health Care  
Provider Name: \_\_\_\_\_

Health Care Provider Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health Care Provider  
Phone Number: \_\_\_\_\_

Health Care Provider  
Fax Number: \_\_\_\_\_