Letter of Medical Necessity

Pretax spending accounts, including flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs), may only reimburse eligible expenses pre-tax as permitted by the IRS.

Certain medical expenses are not reimbursable under a Health Care FSA or HRA, unless a physician or medical practitioner states that the service or product is medically necessary.

Code Section 213(d)

"The term medical care means amounts paid –

(A) For the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,"

When submitting claims for reimbursement for a FSA or HRA, expenses that may be considered "dual purpose" require a Letter of Medical Necessity (LMN). A dual purpose expense is an expense that could be used for both medical and non-medical reasons (i.e. vitamins). In IRS News Release IR-2024-65, the IRS warns that taxpayers are being misled that personal expenses could be medical expenses if such expenses are supported by a LMN. IRS News Release IR-2024-65 also states self-diagnosis is not sufficient to determine medical necessity of a dual purpose expense. In the frequently asked questions about medical expenses related to nutrition, wellness, and general health issued by the IRS on March 17, 2023, dual purpose expenses may be eligible if the patient's physician or medical practitioner has diagnosed a medical condition and recommended a specific item or service to treat the diagnosed medical condition. The IRS has also commented on the need for a LMN in several information letters, including IRS Information Letters 2022-0005 and 2016-0013.

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Section I

Date: _____

Employer Name: _____

Patient Name: _____

Employee Name: _____

Section II (required for expenses specifically requiring an LMN e.g. weight loss programs, vitamins/supplements, etc.) Diagnosis: _____

Treatment Duration Start date: _____ End date: _____

Procedure (CPT) Code or ICD-10 code: _____

Hello Navia Benefits:

(Please describe the **medical condition**, the **treatment you recommend**, and **how such treatment relates** to the diagnosed condition)

_____

_____

_____

Gym/Health Club Memberships:

☐ **Provider** – check the box if the recommended treatment for the above diagnosis is for a gym/health club membership and the cost of membership is only incurred due to the recommendation to treat a specific medical condition and not for general health and well-being. The cost of the membership is only eligible for the duration of the treatment of the specific medical condition listed above. Please list the treatment expiration date below.
Expiration Date: _____

☐ **Participant** – Please initial in the box to certify that this gym/health club membership would not have been purchased but for the existence of the medical condition as diagnosed by my medical provider and would not have been purchased absent the medical condition. I will not submit a claim for reimbursement for any month during which I do not attend the gym/health club.

Provider's signature: _____

By signing this Letter of Medical Necessity I certify under penalty of perjury that I am a license medical provider in the state of_____. I have met with or engaged with the patient using telehealth technologies. Based on my professional assessment and medical evaluation, I understand and/or have diagnosed the above medical condition. In my professional judgment, I recommend the specific treatment or service listed above as medically necessary for the treatment and management of the patient's medical condition. This treatment is essential to the diagnosis, cure, mitigation, treatment, or prevention of the patient's condition.

PROVIDER AGREES TO INDEMNIFY, DEFEND, AND HOLD HARMLESS THE EMPLOYER PLAN AND NAVIA BENEFIT SOLUTIONS, INC. FROM ANY AND ALL CLAIMS, LIABILITIES, DAMAGES, AND EXPENSES, INCLUDING REASONABLE ATTORNEY'S FEES, ARISING OUT OF OR RELATED TO THE EXPENSE BEING CLAIMED AS INELIGIBLE.

If you require any additional information or have any questions, please feel free to contact me at my phone number below.
Clinic/Hospital/Office Name: _____

Address: _____

Phone Number: _____

Participant signature: _____

By signing this Letter of Medical Necessity I certify under penalty of perjury that the expenses for which this LMN supports are eligible medical expenses as defined under Section 213(d) of the Internal Revenue Code. I further attest that the expense(s) for which this LMN will support will be incurred by me or my eligible dependents, the expenses were necessary for the diagnosis, cure, mitigation, treatment, or prevention of disease for me or my dependent(s), the expenses would not have been incurred but for the medical condition for which they are claimed, I have not been reimbursed for these expenses by any other plan, and I will not seek reimbursement from any other source, I understand that any amounts reimbursed that are not for qualified medical expenses under IRC Section 213(d) must be reported as taxable income and may be subject to penalties. I understand that falsifying information or providing misleading documentation may compromise the tax benefit status of the underlying plan, result in disciplinary action, up to and including termination of employment and/or legal action.

EMPLOYEE/PARTICIPANT AGREES TO INDEMNIFY, DEFEND, AND HOLD HARMLESS THE EMPLOYER PLAN AND NAVIA BENEFIT SOLUTIONS, INC. FROM ANY AND ALL CLAIMS, LIABILITIES, DAMAGES, AND EXPENSES, INCLUDING REASONABLE ATTORNEY'S FEES, ARISING OUT OF OR RELATED TO THE LMN IS NOT VALID, THE EXPENSE WOULD HAVE BEEN INCURRED BUT FOR THE MEDICAL CONDITION, OR ANY OF THE EXPENSES CLAIMED DO NOT QUALIFY AS MEDICAL EXPENSES UNDER IRC SECTION 213(d).

Note: Navia Benefits requires that proper documentation support your FSA claims. If your letter is incomplete your claim will be denied.

Please Fax to: 1-866-535-9227 or email to
customerservice@naviabenefits.com

Questions? Please call: 1-800-669-3539