



Letter of Medical Need

P.O. Box 1800, Tallahassee, FL 32302-1800

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

When you enrolled in your Employer's Medical Reimbursement Account (MRA) plan, you agreed to the following:

- I will only use my MRA to pay for IRS-qualified expenses and only for 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 MRA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

People First has developed these instructions to assist you in complying with your 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.

How do I seek reimbursement?

In order for incurred expenses to be reimbursed from your Medical Reimbursement Account, you must follow these instructions. Only the cost of medical care and services permitted under both IRS Code § 213 and your Employer's Medical Reimbursement Account 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 any expense that has a useful life that extends beyond the end of the taxable year, such as an elevator, blood pressure cuff, 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" a medical condition.

A separate Capital Expenditure Worksheet is required when you submit a request for reimbursement of a capital expenditure. For more assistance or to obtain a sample form, contact **People First Service Center** at <https://peoplefirst.myflorida.com> or by calling 1-866-ONE-HRFL (1-866-663-4735); TTY (1-866-221-0269).

Note: If improper reimbursement of ineligible Medical Reimbursement Account expenses has been made, the corrective procedures approved by the IRS and permitted under your Employer's Medical Reimbursement Account will be followed.

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

A Letter of Medical Need must be submitted with your MRA 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.

For recurring expenses that continue for more than one plan year, such as orthodontia, you must submit a new Letter of Medical Need at the start of each plan year you intend to request reimbursement for the expenses.

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 MRA participant's name
- the MRA participant's Social Security number
- the name of the MRA participant's employer
- the patient's name and
- the patient's relationship to the Medical Reimbursement Account 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 MRA 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 **People First Service Center** at <https://peoplefirst.myflorida.com> or by calling 1-866-ONE-HRFL (1-866-663-4735); TTY (1-866-221-0269).

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.

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

Participant's Name: _____ **Participant's Social Security Number:** _____

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

The duration of the participant's treatment is expected to be _____
Duration of Treatment

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: _____