# Do you have a healthcare Flexible Spending Account (FSA)?

Check with your plan administrator to see if an air purifier can qualify for reimbursement. Ask your physician to complete this document for submittal to your plan administrator.

## Letter of Medical Necessity (LMN)

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA) when your doctor or other licensed health care provider certifies that they are medically necessary. **Your provider must indicate your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.**

By submitting this LMN 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.

**Check with your plan administrator as you may only need to submit this form with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new LMN each year – they cannot be approved indefinitely. Submitting this form does not guarantee that the expense will be reimbursed.**

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|---|---|
| **Date:** | **Email Address:** |
| **Account Holder's Name:** | **Account Holders SSN/UserID:** |
| **Patient Name:** | |
| **Diagnosis:** | |
| **Recommended Treatment:** Use an air purifier at home to help reduce airborne allergens. | |
| **How will the treatment alleviate the diagnosis?:** Effective HEPA air purifiers help capture 99.97% of microscopic particles (0.3 microns or larger) from the air that passes through their filters. Helping to reduce airborne allergens is part of an overall treatment program for this patient. | |
| **Begin Date of Treatment:** | **End Date of Treatment:** |
| **Provider Signature:** | |
| **Provider Name:** | |
| **Provider Address:** | |
| **Provider License #:** | **Provider Telephone #:** |