

MAIL TO:
PayFlex Systems USA, Inc.
Flex Dept.
P.O. Box 3039
Omaha, NE 68103-3039
Toll-Free (866) 887-3539



**UT FLEX
LETTER OF
MEDICAL NECESSITY**



FAX TO:
PayFlex System USA, Inc.
Flex Dept.
Toll-Free (877) 230-4283
(No Cover Page Required)
Page 1 of _____

Patient Name: _____

Employee Name: _____

Employee SSN: _____

Employer Name: _____

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition. Complete the following:

1. Describe the diagnosed medical condition being treated (include diagnosis code):

2. Describe the recommended treatment:

3. Indicate the duration of treatment:

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health; and is not for cosmetic purposes to improve appearance.



Signature of Attending Physician

Date

Print Physician Name

Address: _____

Phone: _____

