



benefit strategies  
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## Physician Statement

FAX: (603) 232-1854

Address: PO Box 1300, Manchester, NH 03105-1300

E-Mail: hvdflex@benstrat.com

Employee Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient's relationship to employee: \_\_\_\_\_

**IRS regulations state that flexible spending account plans may NOT be used for general health but only to treat an "existing disease". A new statement will need to be completed for each plan year.**

**Submission of this form does not guarantee reimbursement.**

**Not to be used for OTC Prescriptions**

Condition being treated: \_\_\_\_\_

Treatment plan: \_\_\_\_\_

Length of treatment: \_\_\_\_\_

Description of how treatment plan treats the specific condition:  
\_\_\_\_\_  
\_\_\_\_\_

**I certify that the above treatment is being prescribed to cure, alleviate or mitigate the medical condition listed above and is medically necessary.**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Physician Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_