

**MAIL TO:**  
PayFlex Systems USA, Inc.  
Flex Dept.  
P.O. Box 3039  
Omaha, NE 68103-3039  
(866) 353-9839



**FAX TO:**  
PayFlex Systems USA, Inc.  
Flex Dept.  
(866) 286-6897  
(No Cover Page Required)  
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**LETTER OF  
MEDICAL NECESSITY**

**Must be completed by the TexFlex Participant:**

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

Participant Name: \_\_\_\_\_

Participant's Employer: \_\_\_\_\_

Member Number: \_\_\_\_\_

(This may be your SSN or employer assigned number)

Expenses must be medically necessary in order to qualify for reimbursement. Since some healthcare services and products such as massage therapy and weight loss programs may be for both medical and non-medical reasons, PayFlex may request your Physician to confirm that an expense is recommended for treatment AND is a direct result of a specific diagnosed medical condition.

If requested, this form may be completed and signed by your physician (OR) your physician may submit the same information on signed letterhead stationery. You must attach the Letter of Medical Necessity form or letter to your claim form or to our request for the medical information. Upon receipt, your account will be noted.

**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 Name (First & Last)

**Address:** \_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_