NORTHERN ILLINOIS HEALTH PLAN

Mail / Fax / Email to:
Mailing Address: PO Box 880, Freeport, IL 61032
Fax: (815) 599-7059
E-Mail: NIHPCustomerservice@fhn.org

Medical Necessity / Over-the-Counter Authorization Form

Your medical care provider must complete a Letter of Medical Necessity for any service or product that falls under the category of "Ineligible Expense" per IRS section 213(d)(1). If your provider feels the service or product is medically necessary for you or your tax dependent(s), this form must be completed to allow reimbursement from your Medical Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) Account.

TO BE COMPLETED BY PARTICIPANT (Please print)

Participant Name: _____

Participant Employer: _____

Participant ID#: _____

Patient Name: _____

TO BE COMPLETED BY LICENSED PRACTICTIONER (Please print)

A written prescription can be an acceptable form of proof of medical necessity if it contains the medical condition being treated

Medical Condition: _____

Name and type of medication: _____

Please describe treatment (frequency and/or dosage): _____

_____

_____

Duration of treatment: _____

I certify that this service or product is medically necessary to treat the specific medical condition described above and is not in any way for general health or for cosmetic purposes.

Print name of Licensed Practitioner: _____

Signature of Licensed Practitioner: _____

Date: _____

This statement of medical necessity will remain on file with Northern Illinois Health Plan for one (1) year. Any services or products listed above will be eligible for reimbursement through your Medical FSA or HRA during this time. In order to receive reimbursement for the above listed Over the Counter product, you must complete an FSA or HRA Claim Form (additional documentation is required – see FSA or HRA Claim form for instructions).

I certify that the expenses for which I am seeking reimbursement from my Medical FSA or HRA have been incurred by me, or by an individual who qualifies as my dependent for federal income tax purposes. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including a Health Savings Account. I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal, state or local income tax return.

_____ _____

Employee Signature **Date**