Medical Necessity Form

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

This form is to be completed when submitting "dual-purpose" expenses. Per IRS regulations, dual-purpose expenses are only eligible if recommended by a medical practitioner, as they have both a medical purpose and a personal, cosmetic, or general health purpose. Please complete and submit this form for any dual-purpose expense for which you are requesting reimbursement.

Instructions:

1. Complete all sections of this form.
2. Securely email, mail, or fax completed form and supporting documentation to:

   Secure Email: BenefitHelpSolutionsCDHSupport@healthaccountservices.com

   Address:
   BenefitHelp Solutions
   P.O. Box 2823
   Fargo, ND 58108
   Fax: (855) 778-9837

3. If you have any questions about completing this form, please contact BenefitHelp Solutions Consumer Services at (855) 378-0197.

Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth _____ / _____ / _____	* Social Security number
* Mailing address		* City	* State	* ZIP
* Physical address		* City	* State	* ZIP
* Email address			* Contact phone number	
* Employer				

Updates or changes to your information can be made by logging into your account at: https://www.BenefitHelpSolutions.com

Section 2 Claim information

*Is this form being submitted for a previously denied claim? If neither box is selected, the form will be processed as "no".

☐ Yes ☐ No

If yes, please provide the claim number(s) for which you are submitting this form. Failure to provide the appropriate claim number(s) will result in the Medical Necessity Form being added to your account (if approved) and previous claim denials not being reprocessed.

Claim number	Claim number	Claim number

Section 3 Medical practitioner information

* Name of and type of medical practice	* Phone number
* Medical practitioner or physician printed name	* Medical practitioner or physician signature

Medical Necessity Form

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

Section 4 Medical necessity information

* Recipient of treatment first name	M.I.	* Last name
* Medical diagnosis or diagnosis code – *Example: 724.2 (Lumbar back pain)*		
* Itemized List of Treatment or Product – *Example: Massage therapy; Vitamin C Tablets*		

Section 5 Participant certification

I hereby certify that the reimbursement requests I am submitting are considered medically necessary and are IRS-eligible expenses. I also understand that BenefitHelp Solutions, including its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement.

* Consumer Signature	* Date