



## **Letter of Medical Necessity**

Certain medical expenses are not reimbursable under a Health Care Expense Account unless a licensed health care professional states that the service or product is medically necessary.

IRS Regulation Section 1.213(d)(1) defines “medical care” to include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

Some services or products do not always “treat” a medical condition. For example:

- Vitamins & dietary supplements
- Cosmetic procedures and products
- Weight Loss Programs

IRS Regulation Section 1.213 states that “[an] expenditure which is merely beneficial to the general health of an individual...is not an expenditure for medical care.” Additionally, IRS Revenue Ruling 2003-102 excludes vitamins by stating that vitamins and dietary supplements are “merely beneficial...to general good health” and, therefore, not reimbursable.

If you purchase vitamin C it would not be eligible for reimbursement. However, vitamin C would be eligible if you have scurvy and your doctor completes the attached letter diagnosing the specific medical condition and necessity for vitamin C treatment. Similarly, calcium is not reimbursable unless your doctor has diagnosed you with a specific medical condition—such as osteoporosis.

Weight loss medications are considered “cosmetic” and are not reimbursable. Certain prescribed drugs for weight loss would be reimbursable to treat a medical condition e.g. obesity.

Please have your licensed health care professional complete the attached sections if your claim has been denied or you anticipate its denial. Note that a doctor’s letter satisfying all the required fields is also acceptable.

## Letter of Medical Necessity

### Section I

Date: \_\_\_\_\_

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

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

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

### Section II (required for expenses specifically requiring an LMN e.g. weight loss programs, vitamins/supplements, etc.)

Diagnosis: \_\_\_\_\_

Treatment Duration Start date: \_\_\_\_\_ End date: \_\_\_\_\_

Procedure (CPT) Code: \_\_\_\_\_

#### **Hello Navia Benefits:**

(Please describe the **medical condition**, the **treatment you recommend**, and **how such treatment relates** to the diagnosed condition)

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Provider's signature: \_\_\_\_\_

Clinic/Hospital/Office Name: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

Note: Navia Benefits requires that proper documentation support your Health Care Expense Account claims. If your letter is incomplete your claim will be denied.

Please email to: [customerservice@naviabenefits.com](mailto:customerservice@naviabenefits.com)

Questions? Please call: 800-669-3539