



Horizon Blue Cross Blue Shield of New Jersey

# Letter of Medical Necessity

Horizon Blue Cross Blue Shield of New Jersey

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You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

Your medical care provider must complete a Letter of Medical Necessity for any service or product that falls under the category of "Possible Expense" or "Ineligible Expense" per IRC section 213(d)(1) if your provider believes the service or product is medically necessary for you or your tax dependent(s).

## TO BE COMPLETED BY PARTICIPANT

Participant Name: \_\_\_\_\_  
Last First MI

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

Participant ID#: \_\_\_\_\_ Participant Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First MI

## TO BE COMPLETED BY LICENSED PRACTITIONER

Medical Condition: \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

NOTE: In order for the expense referred to on this Letter of Medical Necessity form to be reimbursed, you the participant must attach the detailed receipt of explanation of Benefit from you medical insurance carrier and complete a FSA Claim Form for Reimbursement (certain expenses may require additional documentation). Documentation must include the date of service and amount charged. These documents are required with each claim that is filed.