

Mail: UPMC Health Plan
 P.O. Box 3169
 Greenwood Village, CO 80155-3169

Phone: 1-888-876-2756
 Fax: 1-866-229-3711

CERTIFICATE OF MEDICAL NECESSITY

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Flexible Spending Account (FSA), Limited FSA and Health Reimbursement Arrangement (HRA) when your physician certifies that they are medically necessary. UPMC Health Plan has developed this Certificate of Medical Necessity (CMN) to assist you and your health care physician in supplying that information needed in order to process your claim. Your physician can also submit a statement on his or her letterhead, as long as the letter includes all of the information that is included on this form. By submitting this CMN, you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition. The Role of UPMC Health Plan is to ensure that the proper documentation is received in order to approve reimbursements under your employer's plan. Furthermore, UPMC Health Plan will review this form for completeness and determine if the recommended treatment meets the eligibility guidelines of the plan document and the IRS as defined in §213 (d).

This form will be denied, without review, if it is not completed in its entirety. The Practitioner Signature must be dated on or before the date of service or purchase. This form will not be accepted in place of a doctor's prescription for the reimbursement of OTC drugs and medicines.

PLAN INFORMATION

EMPLOYER NAME _____ PLAN YEAR _____

EMPLOYEE INFORMATION

COMPLETE THIS SECTION FOR THE PRIMARY ACCOUNT HOLDER

FIRST NAME _____ LASTNAME _____

MEMBER/EMPLOYEE ID NUMBER _____ DAYTIME PHONE _____

EMAIL* _____

* **Email:** By providing your email address you agree to receive MyFlex Advantage Plan correspondence electronically. UPMC Health Plan does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is solely used to administer your benefit account (s). Please add our email address, myflex@upmc.edu, to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your email address by contacting UPMC Health Plan, Member Services at 888-876-2756.

THIS NEXT SECTION SHOULD BE COMPLETED BY YOUR LICENSED PHYSICIAN

MEDICAL CONDITION INFORMATION

PATIENT FIRST NAME _____ PATIENT LAST NAME _____

DIAGNOSIS: _____ CPT CODE: _____

RECOMMENDED TREATMENT: _____

***Products and procedures must be itemized**

DURATION OF RECOMMENDED TREATMENT: _____

***If the duration of treatment extends beyond the end of the current plan year, a new Certificate of Medical Necessity will be required for the next plan year.**

HOW WILL THE TREATMENT IMPROVE OR ELIMINATE THE DIAGNOSED MEDICAL CONDITION AND/OR THE SYMPTOMS:

PHYSICIAN CERTIFICATION AND INFORMATION

I certify that the recommended treatment is medically necessary and is not solely for cosmetic purpose or general good health.

PHYSICIAN SIGNATURE _____ DATE _____

PHYSICIAN NAME _____ LICENSE NUMBER AND STATE _____