

Chard Snyder by one of the

two methods listed to the right

Letter of Medical Necessity Form

Submit documentation on your Chard Snyder online account or on the Chard Snyder Mobile App for quickest processing and reimbursement. Paper forms can be submitted by fax or mail, but expect longer processing times for these methods.

Company Information (PLEASE PRINT)						
Company Name				Division (if applicable)		
Participant Information (PLEASE PRINT)						
Last Name			Prin	Primary Phone		
First Name			Sec	Secondary Phone		
SSN / (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy)			Email Address (For Account Notifications)		
Street Address						
City			Sta	te	Zip	
If the letter of medical necessity is required for claims for a spouse or eligible dependent, please provide the following information						
Patient Name F			Relatio	nship	Date of Birth	
Medical Necessity (TO BE COMPLETED BY YOUR MEDICAL PROVIDER)						
Diagnosis					CPT Code:	
Recommended Treatment						
Explain how this treatment will alleviate the diagnosis or symptoms of the medical condition:						
Date Range of Treatment	From through					
Provider Information and Certification						
Provider Name						
Provider Phone		License #			State	
By signing below, I certify that this service or product is medically necessary to treat the specific medical condition described above and is not for general good health or cosmetic purposes.						
Provider's Signature:				Date		
Participant Certification						
By signing below, I certify that the Medical Necessity and Provider Information and Certification sections were completed by the above treating physician. The expense I am claiming is not for general good health or cosmetic purposes but is the direct result of the medical condition as described above by the healthcare provider. I also understand that this letter of medical necessity does not guarantee that the expense will be reimbursed under my plan.						
Participant Signature (Required)				Date		
SEND THIS FORM TO CHARD SNYDER						
Please submit this form to	Fay:	Local 513 459 9947 / Toll-Free	888 245	8452 (Please DO NOT i	neludo a Fay Coyor	

Page) Mail: PO Box 2924, Fargo, ND 58108-2924

Letter of Medical Necessity Instructions

- Complete all company and participant information on the front page (please print/type). NOTE: Please
 include your e-mail address to receive an automatic e-mail notification whenever a claim is entered into our
 system and when a reimbursement is approved for you to receive payment
- 2. Ask your medical provider to complete the section titled "Medical Necessity" or submit a statement on his or her letterhead providing the information below:
 - ☑ The patient's name
 - ☑ The specific diagnosis
 - ☑ The specific treatment needed
 - ☑ The length of treatment
 - ☑ How this treatment will alleviate the medical condition
- 3. Your provider MUST sign and date the form or statement provided
- 4. You MUST sign and date the "Participant Certification" section on the front of this page
- 5. **Fax or Mail** this form with your claim directly to Chard Snyder:
 - ☐ Fax: Local 513.459.9947 / Toll-Free 888.245.8452 (Please DO NOT include a Fax Cover Page)
 - ☑ Mail: PO Box 2924, Fargo, ND 58108-2924
- 6. If you have questions please contact us:

☑ Call Customer Service: 513.459.9997 | 800.982.7715

✓ Visit our Website: www.chard-snyder.com

- 7. Important Reminders:
 - To ensure your claim is processed as soon as possible, and avoid delays:
 - ✓ Include this letter of medical necessity form or your provider's letter and itemized receipts with your original claim
 - ☑ Only health club memberships obtained <u>after</u> your healthcare provider's recommendation are eligible for reimbursement.
 - ☑ Do NOT use a fax cover page when faxing
 - ☑ Do NOT highlight any part of your receipts, bills, etc.
 - ✓ Only mail copies of receipts, bills, etc. (Keep your originals)
 - ☑ Multiple receipts should be totaled on one claim form
 - ☑ Over-the-Counter medications require a doctor's prescription
 - ☑ Claims may not be paid across accounts (healthcare from dependent daycare and vice versa)
 - Any items for which you are reimbursed cannot be claimed again as deductions or credits on your individual tax return at the end of the tax year
 - ✓ You may only be reimbursed for eligible expenses from the current plan year
 - Payment will be made directly to you. Payments cannot be made to a provider or another person
 - ☑ Cancelled checks are NOT acceptable as proof of payment
 - ☑ Limited healthcare Flexible Spending Accounts may only reimburse claims for dental and/or vision expenses

Please note: If your treatment extends beyond the time period listed by the provider, you will need to submit a new doctor's statement. The maximum time period cannot exceed one year from the date of the doctor's signature. A new form will be required at the end of each one-year period of treatment.

Submission of this form is not a guarantee that the expense will be reimbursed.

Sign up for Direct Deposit on your online account or on the mobile app for quicker reimbursement than receiving a check.