



# 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)
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## Participant Information (PLEASE PRINT)

Last Name		Primary Phone
First Name		Secondary Phone
SSN / (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy)	Email Address (For Account Notifications)
Street Address		
City	State	Zip

*If the letter of medical necessity is required for claims for a spouse or eligible dependent, please provide the following information*

Patient Name	Relationship	Date of Birth

## Medical Necessity (TO BE COMPLETED BY YOUR MEDICAL PROVIDER)

Diagnosis	CPT Code:
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Recommended Treatment

Explain how this treatment will alleviate the diagnosis or symptoms of the medical condition:

<b>Date Range of Treatment</b>	From	through
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## 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
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## 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
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## SEND THIS FORM TO CHARD SNYDER

Please submit this form to Chard Snyder by one of the two methods listed to the right	<b>Fax:</b> Local 513.459.9947 / Toll-Free 888.245.8452 <i>(Please DO NOT include a Fax Cover Page)</i> <b>Mail:</b> P.O. Box 249, Fort Washington, PA 19034
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# Letter of Medical Necessity Instructions

1. **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:** P.O. Box 249, Fort Washington, PA 19034
6. **If you have questions** please contact us:
  - Call Customer Service:** 513.459.9997 | 800.982.7715
  - Visit our Website:** [www.chard-snyder.com](http://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 after 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.