State of Connecticut
Medical Flexible Spending Account
Medical Necessity Form Letter
CO-1308

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	EMPLOYEE NUMBER	DAYTIME PHONE NO
	- -		

HOME ADDRESS (if not on file)	CITY, STATE, ZIP CODE
(☐ Check if new address)	

EMAIL ADDRESS (if not on file)	PATIENT NAME	RELATIONSHIP TO EMPLOYEE

MEDICAL NECESSITY PHYSICIAN SUBSTANTIATION

This section must be completed by the patient's physician responsible for the diagnosis and treatment of the condition detailed below.

I am currently treating ______________________________
PATIENT'S NAME

I certify that the below listed prescribed treatment, service, procedure, equipment, supply and/or capital expenditure is medically necessary to treat the patient identified above and is not intended to merely preserve or promote my patient's general health or well -being, satisfy nutritional needs nor to serve a primary cosmetic, personal, living and/or family purpose.

Identify the Medical Treatment, Service, Procedure, Equipment, Supply and/or Capital Expenditure with the corresponding diagnosis below:

PHYSICIAN NAME & LICENSE NUMBER (PRINT)	PHYSICIAN PHONE NUMBER	PHYSICIAN FAX NUMBER

PHYSICIAN MAILING ADDRESS	CITY, STATE, ZIP CODE

Physician Signature **Date**

SPECIAL VERSION ITEM CERTIFICATION

This section must be completed by the Participant if you are seeking reimbursement for the cost of a medically-necessary special version of an item.

- I understand that if I am seeking reimbursement of a special version of a medically-necessary item, that along with my reimbursement request and the above completed Medical Necessity Form Letter substantiation, I must certify the cost difference between the normal expense and special version expense.
- I understand that only the difference between the cost of the normal expense and special version expense is eligible for reimbursement.

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MEDICALLY-NECESSARY ITEM

Item cost of the above listed item in its normal form $ ______________

Item cost of the above listed item in its special form $ ______________

The difference between the cost of the normal and special version item expense $ ______________

Participant Signature **Date**

Medical Necessity Form Letter Purpose	Expenses may be reimbursed for the employee, their spouse and their IRS eligible dependents so long as: (1) expenses are qualified under IRS Code Section 105 and 213; (2) all other sources of reimbursement are exhausted (ex. health insurance plan); (3) reimbursement will not be sought by any additional source and; (4) documentation to substantiate expenses are maintained and submitted for verification. A sample listing of eligible over-the-counter and medical products and services and ineligible expenses may be downloaded from the OSC website at http://www.osc.ct.gov/empret/medflex/Guidelines%20OTC%20Hlthcare%20Purchases%20Ef fective%202012.DOC or the Plan's administrative services provider, PBS, at www.ctpbs.com or by contacting 866-906-8023. Further information regarding eligible expenses is available through IRS Publication 502 and IRS Code Section 213. Only the cost of medical products and services allowed under the IRS Code Section 213 and the State of Connecticut MEDFLEX Plan Document are eligible for reimbursement. If these medical products and services include expenses tha t can be provided for both a medical and cosmetic, capital expenditure, personal, living and/or family purpose, a Medical Necessity Form Letter must be submitted along with your MEDFLEX Claim Form. The expense whose reimbursement you're seeking reimbursement for must: • Be provided for both a medical purpose and cosmetic, personal, living and/or family purpose and/or • What is a capital expense? A capital expense is defined as an item that has a useful life that extends beyond the end of the taxable year such as special equipment installed in a home or home improvement if the main purpose is: - To provide medical care for you, your spouse or your dependent for an existing medical condition and; - The expense is substantiated as a medical necessity by proving that it would not be medically necessary "but for" the existing medical condition. If a request for a capital expenditure reimbursement is made, a Capital Expenditure Worksheet must accompany the MEDFLEX Claim Form request. You may download a Capital Expenditure Worksheet, which is part of Capital Expense Form (CO-1309), from the OSC website at http://www.osc.ct.gov/empret/medflex/oldforms/CO-1309-rev-11-13.rtf, the PBS website at www.ctpbs.com, or by contacting 866-906-8023.
Eligible Expenses	Eligible expenses must be prescribed treatments, services, procedures, equipment, supplies and/or capital expenditures that are medically necessary to treat the specific medical condition identified on the Medical Necessity Form Letter and is not intended to merely preserve or promote a patient's general health or well-being, satisfy nutritional needs nor to serve a primary cosmetic, personal, living and/or family purpose. See IRS Publication 502 and IRS Code Section 213 and the State of Connecticut MEDFLEX Plan Document for additional information. Reimbursement requests for recurring expenses that span plan years, such as dental work, must have a Medical Necessity Form Letter at the start of each Plan Year.
Instructions	In order to accurately process your claim, please complete the Medical Necessity Form Letter section in its entirety. The physician responsible for the patient's diagnosis and the treatment of the condition specified must complete the Medical Necessity Physician Substantiation section before a MEDFLEX Claim Reimbursement is submitted. If the request is for a medical treatment not normally associated with the condition certified by your physician in the Medical Necessity Form Letter, additional substantiation may be requested. **Every plan year a new medical necessity form must be submitted.** If you are requesting reimbursement for a special version of a medically -necessary item, complete the Special Version Item Certification section in its entirety. You must indicate the cost of the normal and special version item. You will be reimbursed for the cost difference between the normal and special version item expense.

KEEP A COPY FOR YOUR RECORDS

MAIL OR FAX COMPLETED FORM TO: Progressive Benefit Solutions, LLC (PBS), 14 Business Park Drive #8, Branford, CT 06405
CLAIMS FAX: (203) 974-4890 Phone: 1-866-906-8023 Local # (203) 985-1712