



Letter of Medical Necessity

FOR SUBMISSION TO AN HSA, FSA OR HRA PLAN ADMINISTRATOR

DATE _____ CLIENT _____ DATE OF BIRTH _____
PLAN ADMINISTRATOR _____ MEMBER / ACCOUNT # _____

To whom it may concern,

I am the treating physical therapist for the client named above. This letter is provided at their request to document the medical necessity of the physical therapy services described below, for the purpose of reimbursement from a health savings account, flexible spending account or health reimbursement arrangement.

CONDITION BEING TREATED

RELEVANT FINDINGS FROM EXAMINATION

SERVICES RECOMMENDED, AND WHY THEY ARE MEDICALLY NECESSARY FOR THIS CONDITION

FREQUENCY _____ EXPECTED DURATION _____ START DATE _____

These services are being provided to treat the specific condition described above. They are not being provided for general health, general fitness or personal comfort. In my clinical judgment they are medically necessary for this client, and I expect to re-evaluate their necessity as treatment progresses.

Please contact me directly if you require any further detail to process this claim.

Sincerely,

David Naputi, PT, DPT

Founder, Rooted Motion Physical Therapy, PLLC

VA LICENSE # _____

NPI _____

SIGNATURE _____

Most plan administrators treat a letter of medical necessity as valid for one year from the date written, and some require it to be renewed sooner for ongoing services. Eligibility rules vary by plan. This letter documents clinical necessity; it is not tax advice, and it does not guarantee that your plan will reimburse the expense.