OPTUM Bank®

Medical Practitioner Statement of Medical Necessity

Submit this form as certification from your licensed medical practitioner that expenses incurred for services and products are medically necessary. Include the corresponding **claim form and documentation** when you return this form in order to support your claim for reimbursement. The completion and submission of this form does not guarantee that the associated expenses will be approved for reimbursement under your health care expense reimbursement plan. By submitting this form, with a corresponding claim form, you certify that the expenses you are claiming are a direct result of the medical condition described by your medical practitioner. A new Statement of Medical Necessity must be submitted each 12 months.

Questions? Visit us online at optumbank.com or call the number on the back of your debit card if you have any questions while completing this form.

1016 HA FSA HRA RRA

1 About you

Employee Name:	Last 4 of SSN:
Employer/Plan Sponsor Name:	

2 Explanation of Medical Necessity

Diagnosis:	CPT Code:
Recommended Treatment:	
How will this treatment alleviate the diagnosis?	
Start date of treatment:	End date of treatment (not to exceed 12 months):

3 Medical Practitioner Information and Signature

Practitioner Name:

Provider License #:

Name of Practice:

Practitioner Phone #:

x _____ _____

Medical Practitioner's Signature | Date

Where to return your form?

By Mail: Optum Bank, P.O. Box 30516, Salt Lake City, UT 84130

By Fax: 1-855-244-5016