



CERTIFICATE OF MEDICAL NECESSITY

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Health Flexible Spending Account when your physician certifies that they are medically necessary.

Planned Benefit Systems, Inc. has developed this certification to assist you and your health care physician in supplying the information needed in order to process your claim. Your physician can also submit a statement on his or her letterhead, as long as the letter includes all the information that is included on this form.

The Role of Planned Benefit Systems, Inc. is to ensure that the proper documentation is received in order to approve reimbursements under your employer's plan. Furthermore, PBS will review this form for completeness and determine if the recommended treatment meets the eligibility guidelines of the plan document and the IRS as defined in §213 (d). **This form must be completed in its entirety.**

PLAN INFORMATION

EMPLOYER NAME _____ PLAN YEAR _____

EMPLOYEE INFORMATION

Complete this section for the primary account holder.

FIRST NAME _____ LAST NAME _____ SSN _____

DAYTIME PHONE _____ EMAIL¹ _____

¹ **Email:** By providing your email address you agree to receive Employee Benefit Plan correspondence electronically. Planned Benefit Systems, Inc. does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is used solely to administer your benefit account(s). Please add our email address, help@cci-pbs.com, to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your e-mail address by contacting the PBS, Inc. Customer Service Department or by visiting our website at www.cci-pbs.com. Select *Planned Benefit Systems*, then *Account Information* under the Participants section and then log in under Employee and Cardholder Login. PBS, Inc. reserves the right to utilize an email address that may be provided to us by your employer.

MEDICAL CONDITION INFORMATION

The next two sections should be completed by your licensed physician.

PATIENT FIRST NAME _____ PATIENT LAST NAME _____

DIAGNOSIS: _____

RECOMMENDED TREATMENT: _____

DURATION OF RECOMMENDED TREATMENT: _____

***If the duration of treatment extends beyond the end of the current plan year, a new Certificate of Medical Necessity will be required for the next plan year.**

HOW WILL THE TREATMENT IMPROVE OR ELIMINATE THE DIAGNOSED MEDIAL CONDITION AND/OR THE SYMPTOMS:

PHYSICIAN CERTIFICATION AND INFORMATION

I certify that the recommended treatment is medically necessary and is not solely for cosmetic purpose or general good health.

PHYSICIAN SIGNATURE _____ DATE _____

PHYSICIAN NAME _____ LICENSE NUMBER AND STATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

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