Medical Determination Form

You may submit this completed form to Vantage Flex via facsimile at 866-511-5503.

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Patient Name:

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Participant's Employer:

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Participant's Name:

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Participant's Social Security Number:

This form should be completed by the attending physician to confirm treatment is necessary to treat a specific medical condition or disease. This form may be used for specific treatments and dual purpose over the counter expenses. PLEASE NOTE THAT THIS FORM MUST ACCOMPANY THE RECEIPT AND WILL BE REVIEWED FOR ELIGIBILITY UNDER YOUR EMPLOYER'S PLAN. THE COMPLETION OF THIS FORM BY A DOCTOR DOES NOT GUARANTEE REIMBURSEMENT. All expenses must meet the criteria for 213(d) medical expenses for reimbursement.

1. Describe the diagnosed medical condition or disease that requires treatment.

2. List the date of the onset and/or diagnosis of the medical condition or disease.

3. Describe the specific recommended treatment.

4. Indicate the length of the treatment.

Please note that the duration of treatment must not exceed the end of your current plan year and is not being incurred but for the diagnosed medical condition or disease. We must have a current letter on file from your practitioner each active plan year for reimbursement consideration of your dual purpose expense.

Physician: I certify that this treatment is medically necessary to treat the specific medical condition or disease described above. This treatment is in no way for general health and is not for cosmetic purposes.

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Physician's Signature	Date
____	____________________
Print Name	Phone Number

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Address of Physician