HealthTrust
Benefit Advantage

Physician Statement

FAX: 603.415.3099
Telephone: 603.226.2861 or 800.527.5001
Address: PO Box 617, Concord, NH 03302-0617
Email: benefitadvantage@healthtrustnh.org

Employee Name: _____ Employer: _____

Patient Name: _____ Last 4 of Employee SSN: _____

Patient's relationship to employee: _____

IRS regulations state that flexible spending account plans may NOT be used for general health but only to treat an "existing disease". Submission of this form does not guarantee reimbursement.

Not to be used for OTC Prescriptions

Condition being treated: _____

Treatment plan: _____

Length of treatment: _____

Description of how treatment plan treats the specific condition:

_____

_____

I certify that the above treatment is being prescribed to cure, alleviate or mitigate the medical condition listed above and is medically necessary.

Physician Signature: _____ Date: _____

Print Physician Name: _____

Practice Name: _____

Contact Information: _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____