

HEALTH & BENEFIT ACCOUNTS

Medical necessity form

Instructions: Please complete and submit this form for any dual-purpose expenses for which you are requesting reimbursement. A dual-purpose item is defined as having both a medical purpose and a personal, cosmetic or general health purpose and per the IRS regulations is only eligible for reimbursement if recommended by a doctor or other licensed health care provider.

Please mail or fax the completed form to:

Bank of America
 c/o Health Account Services
 PO Box 2203
 Fargo, ND 58108
 Fax: 844.590.0919

We're here to help you 24 hours a day, 7 days a week.



Customer Care Center:
 800.718.6710



Online Chat:
myhealth.bankofamerica.com

All fields are required.

Step 1: Customer information

<input type="text"/>		<input type="text"/>	
Employer name (If HSA is provided by employer)		Customer name (First, middle initial, last)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Birth date (MM/DD/YYYY)	Social Security number	Day telephone number	
<input type="text"/>		<input type="text"/>	
Street address		Email address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City	State	Zip code	

Continued on next page.

Step 2: Claim information

Is this form being submitted for a previously denied claim?

Yes No

If “yes”, please provide the claim number(s) in the below boxes. If the claim numbers are not included the previous claims will not be processed. If you select “no” or leave blank the Medical Necessity Form will be added to your account for any future claims.

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Claim number

Claim number

Claim number

Step 3: Medical practitioner information (to be completed by medical practitioner)

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Name of and type of medical practice

Telephone number

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Medical practitioner or physician printed name

Medical practitioner or physician signature

Step 4: Medical necessity information

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Recipient of treatment (First, middle initial, last)

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Medical diagnosis or diagnosis code — Example: 724.2 (Lumbar Back Pain)

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Treatment — Example: Massage therapy

Step 5: Customer certification

I hereby certify that the reimbursement requests I am submitting are considered medically necessary and are IRS-eligible expenses. I also understand that Bank of America, including its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I understand this document is valid for 12 months from date of signature.

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Signature

Date (MM/DD/YYYY)