



LETTER OF MEDICAL RECOMMENDATION

If a letter of doctor's note is required, please include this form with each claim filing

This form should be completed by your physician to confirm treatment is recommended to treat a specific medical condition. All fields must be completed for this letter to be accepted. If vitamins/supplements are being recommended, your physician must specify each individual supplement needed to treat the medical condition listed. Use additional sheets if necessary. Letters of Medical Recommendation will expire after 1 year.

Please provide the following information (please print clearly)

Employee Name: _____

Employee ID: _____

Employer Name: _____

Describe the diagnosed condition being treated:

Describe the specific recommended treatment:

Indicate the duration of treatment:

Read the following and sign/date

This treatment is recommended to treat the medical condition referenced above. This treatment is not for general health purposes, to improve the appearance or for cosmetic services.

Physician Signature: _____ Date: _____

Print Name: _____ Phone: _____

Address: _____