



THIS FORM CAN BE USED TO ***SUBSTANTIATE OTC MEDICINES*** AND/OR AS A ***LETTER OF MEDICAL RECOMMENDATION***. PLEASE HAVE YOUR HEALTH CARE PROVIDER COMPLETE THE PART OF THE FORM THAT IS APPLICABLE TO YOUR CLAIM. All fields in the appropriate section must be completed. Use additional sheets if necessary.

Please provide the following information (please print clearly)

Employee Name: _____ Employee ID: _____

Employer Name: _____

Over the Counter Medicine Prescription (The IRS requires that all OTC Medicine be prescribed to be reimbursed tax free.)

List the specific prescribed over the counter medications:

Health Care Provider Signature: _____ Date: _____

Print Name: _____ Phone: _____

License Number: _____ DEA No: _____

Address: _____

The Health Care Provider acknowledges that this is a Prescription lawfully issued according to the state law in which it was written. Please do not provide the DEA Number unless required on all prescriptions by state law.

LETTER OF MEDICAL RECOMMENDATION (e.g. Massage Therapy, Weight Loss Programs, Nutritionist Expenses) Unless otherwise noted by your physician, this form will expire after 1 year.

Describe the diagnosed condition being treated:

Describe the specific recommended treatment: If vitamins/supplements are being recommended, your physician must specify each individual supplement needed to treat the medical condition listed.

Indicate the duration of treatment:

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: _____