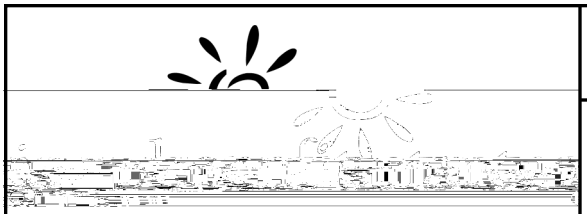

Physician Statement

FAX: (603) 647-4668
Address: PO Box 1300, Manchester, NH 03105-1300
E-Mail: Flexdept@benstrat.com

Employee Name _____ Employer: _____

Patient Name: _____

3DWLHQW·V UHODWLRQVKLS WR HPSOR\HH _____

IRS regulations state that flexible spending account plans may NOT be used for general health but only WR WUHDW DQ ´H[LVWLQJ GLVHDVHµ $QHZ VWDWHPHQW ZLOO
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: _____