Letter of Prescription

In order certain items and services to be eligible for the Flexible Spending Account (FSA) and/or Health Savings Account (HSA), it is necessary to have a letter of medical necessity (LOMN) completed by a physician for each participant. Please check ALL boxes that apply to your patient(s), and list any dependents that may also have expenses to run through a FSA and/or HSA.

PATIENT(S):

Name (Last, First, Middle Initial)	Date of Birth	Address
Name (Last, First, Middle Initial)	Date of Birth	Address
Name (Last, First, Middle Initial)	Date of Birth	Address
Name (Last, First, Middle Initial)	Date of Birth	Address

OTC ITEMS *(If a specific brand name is required please specify on the line provided):*

- ☐ Acid Controllers ______________________
- ☐ Allergy & Sinus ______________________
- ☐ Antibiotic Products ______________________
- ☐ Anti-Diarrheal ______________________
- ☐ Anti-Gas ______________________
- ☐ Anti-Itch & Insect Bite ______________________
- ☐ Anti-Parasitic Treatments ______________________
- ☐ Laxatives ______________________
- ☐ Motion Sickness ______________________
- ☐ Pain Relief ______________________
- ☐ Respiratory Treatments ______________________
- ☐ Sleep Aids & Sedatives ______________________
- ☐ Stomach Remedies ______________________
- ☐ Baby Rash Ointments/Creams ______________________
- ☐ Cold Sore Remedies ______________________
- ☐ Cough, Cold & Flu ______________________
- ☐ Digestive Aids ______________________
- ☐ Feminine Anti-Fungal/Anti-Itch ______________________
- ☐ Hemorrhoid Preps ______________________

(OTHER) Name or Description:	Diagnosis or Purpose of Prescription:
☐ ______________________	______________________
☐ ______________________	______________________
☐ ______________________	______________________
☐ ______________________	______________________
☐ ______________________	______________________

Name of Physician______________________ Signature ______________________

Name of Practice ______________________ Tax ID ______________________ Date__________