



Under IRS rules, some health care services and products are only eligible for reimbursement from your medical reimbursement account when your doctor or other health professional certifies that they are necessary.

PRESCRIPTION FORM FOR OVER-THE-COUNTER (OTC) MEDICATION

EMPLOYEE INFORMATION

Date Requested: _____

Account Holders _____

Name: _____

Patients Name: _____ Last four of SSN: _____

RECOMMENDATION DETAILS (COMPLETED BY THE PROVIDER)

Medication(s) or drug(s) being prescribed:

HEALTH PROFESSIONAL INFORMATION

Certification: This treatment is not for general health or cosmetic purposes.

Name of Health professional _____

Signature of Health Professional _____ Date _____

Instructions to Flexible Spending Account (FSA) Plan Participant:
Attach this completed document to your 24HourFlex Claim Form and fax, email or mail both items to 303-369-0003, 1-800-837-4817, or claims@24hourflex.com. This information is strictly confidential and will be used only for the purpose of processing claims. You must have this form completed and submitted each plan year.