



**HEALTH PROFESSIONAL'S RECOMMENDATION**

**EMPLOYEE INFORMATION**

Date Requested: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone/Extension: \_\_\_\_\_

**RECOMMENDATION DETAILS**

Medication, medical service, or medical device being recommended:

\_\_\_\_\_  
\_\_\_\_\_

Physical or mental ailment this is attempting to diagnose, prevent, treat or cure:

\_\_\_\_\_  
\_\_\_\_\_

You are recommending something that normally is not eligible for reimbursement from a Cafeteria Flexible Spending Account. Please explain why this item is medically necessary:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEALTH PROFESSIONAL INFORMATION**

Name of Health professional \_\_\_\_\_

Signature of Health Professional \_\_\_\_\_ Date \_\_\_\_\_

Name and type of practice \_\_\_\_\_

**Instructions to Flexible Spending Account (FSA) Plan Participant:**

Attach this completed document to your 24HourFlex Claim Form and fax, e-mail, or mail both items to 303-369-0003, 1-800-837-4817, or [claims@24hourflex.com](mailto:claims@24hourflex.com)