DAKOTACARE ADMINISTRATIVE SERVICES, INC.

Letter of Medical Necessity
for Flexible Spending Account (FSA)

*This is to use Flex dollars for a medical expense not normally considered an eligible expense (ex: weight loss programs, massage therapy, or over the counter medications). These expenses can be considered eligible with this form or a prescription.

Patient Name: _____

Employee Name: _____

Last four numbers of SSN: _____

Employer Name: _____

1. Describe diagnosed medical condition (include diagnosis code):

_____
_____
_____
_____

2. List recommended service/equipment for condition:

_____
_____
_____
_____

3. Duration of time service/equipment for condition is needed (maximum of one year):

_____
_____
_____

_____ _____
Signature of Attending Physician Date

_____ _____
Print Physician Name Print Facility Name

DASFLEX 5300 S Broadband Lane Sioux Falls, SD 57108
Phone: 605-322-4774 Fax: 605-504-9305 Toll-Free: 1-888-322-2115
Email: dasflex@averahealthplans.com