FAX: 585-389-7003
Submit or view claims **ONLINE: www.paychex.com/login**
Paychex Employee Services: 877-244-1771
Representatives available Monday – Friday 8:00 a.m. – 8:00 p.m. ET

FOR OFFICE USE ONLY
Docket # ________

PAYCHEX®

Health Flexible Spending Account (FSA) Reimbursement Claim Certificate of Medical Necessity

EMPLOYEE INFORMATION (print)

Employee Name ________________________ Company Name ________________________

Social Security Number (last 4 digits) ________________ Employee Telephone Number (____) _____ - _________

E-mail Address ____

Internal Revenue Service guidelines dictate that certain health care services and products are only eligible from a Health Flexible Spending Account when a doctor or other licensed health care provider certifies that they are medically necessary to treat a specific medical condition.

Under certain conditions, these expenses could also be considered cosmetic and/or for general health purposes and may not be eligible for reimbursement.

This form is not acceptable for reimbursement of Over-the-counter medicine items. Please obtain a separate prescription from your medical practitioner for those items.

This certificate must be completed, signed by your health care provider, and submitted along with an FSA Reimbursement Form (FSA003) and itemized receipts. A new certificate will need to be submitted each calendar (plan) year. Complete all sections of the form in order to avoid a delay in the processing of your claim.

NAME OF SERVICE RECIPIENT	RELATIONSHIP TO EMPLOYEE
MEDICAL CONDITION/DIAGNOSIS	DURATION/TIMEFRAME OF TREATMENT
RECOMMENDED TREATMENT/SERVICE/PRODUCTS AND PURPOSE	

PROVIDER INFORMATION

Provider Name ____

Provider Signature ________________________________ **Date** ______ /________ /_______

Fax your claim information to the number noted above. Retain a copy for your records.