GROUP BENEFIT ADMINISTRATORS OF CONNECTICUT

FSA MEDICAL NECESSITY FORM

Employer Name: ____

Employee Name:	Last First MI	**SS#**	
Address:	Street City State Zip	**Phone:**	( )

Please check if this is a new address

* Information below must be completed

MEDICAL NECESSITY PHYSICIAN SUBSTANTIATION
This section must be completed by the patient's physician responsible for the diagnosis and treatment of the condition detailed below.
I am currently treating: PATIENT'S NAME
I certify that the below listed prescribed treatment, service, procedure, equipment, supply and/or capital expenditure is medically necessary to treat the specific medical condition of the patient identified above and is not intended to merely preserve or promote my patient's general well-being, satisfy nutritional needs nor to serve a primary cosmetic, personal, living and/or family purpose.
Identify the Medical Treatment, Service, Procedure, Equipment, Supply and/or Capital Expenditure below:
PHYSICIAN NAME & LICENSE NUMBER: (PRINT)
PHYSICIAN MAILING ADDRESS: (STREET) CITY, STATE, ZIP CODE
Physician Signature: **Date**

Employee Signature: ____**Date:** ____________________

KEEP THE ORIGINAL COPY FOR YOUR RECORDS

RE-SUBMIT A COPY WITH THIS CLAIM & ALL SUBSEQUENT CLAIMS FOR THIS CONDITION

FAX TO: 203.234.1139
OR MAIL TO:
GBAC
23 MAIDEN LANE
NORTH HAVEN, CT 06473

(01/2010)