



Please fax, email, or mail to:  
Goldleaf Partners  
Employee Benefits  
PO Box 806  
Brainerd, MN 56401

Email: [benefits@goldleafpartners.com](mailto:benefits@goldleafpartners.com)  
Phone: 866.882.8442  
Fax: 844.756.9743

## LETTER OF MEDICAL NECESSITY

On occasion a participant may need to prove that an item or service is medically necessary. Generally, this occurs when an item purchased or service provided is considered "dual purpose." Dual purpose items or services have both a medical purpose and a personal/cosmetic or general health purpose. If an item you purchased or service you received fits this category, please complete this form with your provider and send it to Goldleaf Partners along with your reimbursement request form and claim substantiation. Submitting this form does not guarantee that the expense will be reimbursed.

### 1. Participant Information (Please print or type)

<input type="text"/>			<input type="text"/>		
Employee Name (First, MI, Last)			Employer Name		
<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>
Social Security Number (Last 4 digits)			Patient Name		
<input type="text"/>			<input type="text"/>		
Email address			Phone Number		

### 2. Medical Provider Information (Please print or type)

<input type="text"/>	<input type="text"/>
Medical Provider Name	Phone Number
<input type="text"/>	
Name and Type of Medical Practice	
<input type="text"/>	<input type="text"/>
Address	City, State, Zip
<input type="text"/>	<input type="text"/>
Provider Signature	Date

### 3. Medical Necessity Information (Please print or type)

Medical Diagnosis (not codes). Please provide as much information as possible.

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Specific treatment or medication medically necessary for diagnosis (please include duration if applicable).

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

I hereby certify that the reimbursement request(s) I am submitting are considered medically necessary and would not be purchased or incurred except for the medical diagnosis listed above. I understand that this letter of medical necessity will be valid for one year beginning on the date this form was signed by the provider.

<input type="text"/>	<input type="text"/>
Participant Signature	Date