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

Email: 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)

Employee Name (First, MI, Last)

Employer Name

Social Security Number (Last 4 digits)

Patient Name

Email address

Phone Number

2. Medical Provider Information (Please print or type)

Medical Provider Name

Phone Number

Name and Type of Medical Practice

Address

City, State, Zip

Provider Signature

Date

3. Medical Necessity Information (Please print or type)

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

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

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.

Participant Signature

Date