



**PROGRESSIVE BENEFIT SOLUTIONS, LLC**  
**FSA MEDICAL NECESSITY FORM (03/2026)**

**Employer Name:** \_\_\_\_\_

<b>Employee Name:</b>	Last	First	MI	<b>SS#</b>	
<b>Address:</b>	Street	City	State	Zip	<b>Phone:</b> ( )

*Every 12 months or new Plan Year, a new Letter of Medical Necessity is required (unless otherwise specified).*

\* 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:

DIAGNOSIS CODE  
**(Required):**

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 (Non-electronic signature required) :**

**Date**

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Office Official Stamp:**

**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 , EMAIL TO CLAIMS.SUPPORT@PBSCARD.COM OR MAIL TO:

**PROGRESSIVE BENEFIT SOLUTIONS, LLC**  
**14 BUSINESS PARK DRIVE #8, BRANFORD, CT 06405**