Doctor's Statement for OTC & Other Non Prescription Health Care Expenses

Effective 01/01/2011 the IRS will no longer allow reimbursement of Over-The-Counter (OTC) health care items in an FSA or HRA without a doctor's statement of medical need. The Affordable Health Care Act of 2010 passed legislation that mandates this requirement. A doctor must (1) indicate that you or a member of your family has a specific medical disorder, (2) propose a treatment plan, and (3) state how the treatment will help the medical condition. (4) The duration of the treatment is also required.

To facilitate processing of your reimbursement request Universal Plan has developed this form for your use. If you or your doctor would prefer, you may have the doctor use his own letterhead, but we will need all the information below. We have included multiple diagnosis/treatments on this page if you are currently using more than one OTC item and the doctor wishes to fill out the form for those multiple items. Hopefully, doctors will prescribe most items for one year so participants won't have to be bothered with multiple doctor visits to obtain substantiation.

Please include this statement when sending your receipts for OTC items and one of our itemized vouchers.

Employee Name: _____
Company Name: _____

Patient Name: _____
Diagnosis: _____
Recommended treatment: _____

_____
How will the treatment alleviate the symptoms: _____
Duration of treatment: _____

Patient Name: _____
Diagnosis: _____
Recommended treatment: _____

_____
How will the treatment alleviate the symptoms: _____
Duration of treatment: _____

Patient Name: _____
Diagnosis: _____
Recommended treatment: _____

_____
How will the treatment alleviate the symptoms: _____
Duration of treatment:_____

Patient Name: _____
Diagnosis: _____
Recommended treatment: _____
How will the treatment alleviate the symptoms: _____
Duration of treatment : _____

Patient Name: _____
Diagnosis: _____
Recommended treatment: _____

_____
How will the treatment alleviate the symptoms: _____
Duration of treatment : _____

Provider Name: _____ **Phone Number**: _____
Address: _____ **Signature**: _____
Date: _____