Medically Necessity

I have determined that the use of the following product(s)_____ are necessary and useful for the mitigation, cure, treatment, or prevention of disease, and for the purpose of affecting any part or function of the body and thus may be eligible for my patients HSA or FSA reimbursement.

Patient:_____

Health Care Provider:_____
Address:_____

This document is meant to support the reimbursement documentation used by the patient.