

Some healthcare services and products may be reimbursed only when your provider (doctor or other healthcare expert) confirms that they are medically necessary. Please ask your provider to fill out this form so we can process your claim. As an option, your doctor can send a statement on his or her letterhead. It must include all of the information asked for on this form. Sending the form does not guarantee that the expense will be reimbursed.

Your doctor must specify:

- Your (or your spouse’s or dependent’s) exact diagnosis
- The treatment needed
- Length of treatment
- How it will help or affect your condition


By sending this form you confirm that:

- The expenses you are claiming are a direct result of the condition described below.
- You would not have these expenses if you were not being treated for this condition.

If you are claiming health club membership fees, you must confirm that you were not already a member of a health club.

You only need to send this form, or your doctor’s letter, with your first claim for the service or product. If the treatment goes beyond the timeframe listed, you must send a new form or letter covering the new timeframe. You will need to send a new FSA Medical Necessity Form each year.

Note: Our role is to make sure that the proper documentation is sent for reimbursement under the plan. We review this form for completeness and to make sure that the treatment meets IRS rules and our eligibility standards.

Date (MM/DD/YYYY)		Member’s Email Address	
Member’s Name		Member’s QualChoice ID No.	
Patient Name <i>(If same as Member, mark “SAME”)</i>			
Diagnosis		CPT Code	
Recommended Treatment			
How will the treatment alleviate the diagnosis?			
Beginning Date of Treatment (MM/DD/YYYY)		Ending Date of Treatment <i>(not to exceed 12 months)</i> (MM/DD/YYYY)	
Provider Name		Provider Phone No.	Provider License No.
Provider Mailing Address		City	State Zip
Provider Signature		 Fax completed form to: 855.800.0938	

Statement of Non-Discrimination

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

QualChoice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact QualChoice Customer Service at 501-228-7111 (TTY: 711).

If you believe that QualChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: QualChoice Civil Rights Coordinator, P.O. Box 25610, Little Rock, AR 72221, 501-228-7111 (TTY: 711), Fax 501-707-6729, QCA_COE@qualchoice.com. You can file a grievance by mail, fax, or email. If you need help filing a grievance, QualChoice is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Declaración de no discriminación

QualChoice cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. QualChoice no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

QualChoice:

- Proporciona ayuda y servicios gratuitos a las personas con discapacidad para que se comuniquen eficazmente con nosotros, tales como:
 - Intérpretes calificados de lenguaje por señas
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios de idiomas a las personas cuyo lenguaje primario no es el inglés, tales como:
 - Intérpretes calificados
 - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con QualChoice Customer Service a 501-228-7111 (TTY: 711).

Si considera que QualChoice no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: QualChoice Civil Rights Coordinator, P.O. Box 25610, Little Rock, AR 72221, 501-228-7111 (TTY: 711), Fax 501-707-6729, QCA_COE@qualchoice.com. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, QualChoice está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Los formularios de queja están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.

QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government:

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-235-7111 (TTY: 711).

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

Marshallese

LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe am ejjelok wōñāān. Kaalok 1-800-235-7111 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711)。

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-235-7111 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-235-7111 (رقم هاتف الصم والبكم: 711).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-235-7111 (TTY: 711)まで、お電話にてご連絡ください。

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-235-7111 (TTY: 711) पर कॉल करें।

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).