Doctor's Statement Form

The Internal Revenue Service requires a doctor's statement be provided for certain healthcare expenses in order to be reimbursed from your healthcare Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA). The doctor's statement must indicate the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

This form will assist you and your healthcare provider in providing the information we need in order to process your reimbursement request. Your provider can also write a letter on his or her letterhead, as long as the letter includes all the information on this form.

In addition to the information from your provider, certain expenses require a "but for" statement from the employee noting that the expense would not have been purchased had it not been for the provider's recommended treatment plan. A "but for" certification section is also included in the form, which should be completed by you to ensure all required information is on file.

For fast and accurate processing of your reimbursement request, please make sure to include this doctor's statement form or your provider's letter and the employee "but for" statement along with an itemized receipt or other documentation. The reimbursement request claim form can be found on the self-service employee web site provided by your employer. Please be sure to print the requested information clearly on all documentation submitted.

Please note: *If your treatment extends beyond the time period listed by the provider, you will need to submit a new doctor's statement form upon expiration of the initial treatment dates. The maximum time period provided on the form cannot exceed one year from the date of the doctor's signature. If treatment extends beyond one year, a new form will be required at the end of each one-year period.*

Send the completed form with the signature of the healthcare provider and participant to:

FAX:

Spending Account Management
1-866-643-2219 Toll-free

MAIL:

ADP Spending Accounts
P.O. Box 34700
Louisville, KY 40232

Submission of this form is not a guarantee that the expense will be reimbursed.

(continued)

Doctor's Statement Form

Please print clearly with blue of black ink or type. Signature sections must be signed.

Employee name	
Alternate ID/SSN	
E-mail	
Phone	
Employer	
Patient name	
Diagnosis/Diagnosis code	
CPT code	
Recommended treatment (must be explained in detail)	
How will the recommended treatment alleviate the diagnosis or symptoms?	
Date treatment began	
How long is the treatment required?	
Additional comments	
Provider name and title	
Provider address	
Provider phone	
Provider license # and state	
Provider signature	
Date	
Employee certification	By signing below, I certify that this expense would not have been incurred "but for" the recommendation of the healthcare provider.
Employee signature	
Employee printed name	
Date	

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