

## Letter of Medical Necessity

Participant Name: \_\_\_\_\_  
Participant's Employer: \_\_\_\_\_  
Participant SSN: \_\_\_\_\_  
Daytime Phone Number: \_\_\_\_\_  
Email: \_\_\_\_\_

---

This form should be completed by the attending physician to confirm treatment is medically necessary for a specific medical condition. Complete the following:

- 1. Diagnosis:** \_\_\_\_\_ **CPT Code:** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_ **CPT Code:** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_ **CPT Code:** \_\_\_\_\_
- 2. Treatment Prescribed:** \_\_\_\_\_  
\_\_\_\_\_
- 3. Duration of treatment:** \_\_\_\_\_

---

*This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health and is not for cosmetic purposes to improve appearance or relieve stress.*

\_\_\_\_\_  
**Attending Physician Signature**

\_\_\_\_\_  
**Date**

**PLEASE PRINT:**

Physician Name:	_____
Address:	_____
Telephone:	_____

**Mail, fax or email completed form to:**

Stanley, Hunt, DuPree & Rhine  
SHDR Flexible Reimbursement  
PO Box 6400  
Greenville, SC 29606  
1-252-293-9048 or 1-252-293-9049  
[shdrflexclaims@shdr.com](mailto:shdrflexclaims@shdr.com)

**Fax:**  
**Email:**