PHILIPS sonicare

Letter of Medical Necessity

Flex Spending Accounts (FSA) / Health Reimbursement Arrangement (HRA) / Health Savings Accounts (HSA)

Under IRS and CRA guidelines, some healthcare products are eligible for (a) reimbursement through an FSA/HRA, or (b) treatment as a tax-free distribution from an HSA only if it can be shown that the products are medically necessary. If a dental professional has diagnosed a medical condition and recommended a Philips Sonicare power toothbrush and/or water flosser as treatment or mitigation for the medical condition, under IRS guidelines it should qualify for reimbursement through an FSA/HRA and for tax-preferred treatment for an HSA. Some plans may restrict reimbursement beyond the IRS requirements. Dental professionals: If your patient participates in an FSA, HRA or HSA program, and they purchase a Philips Sonicare power toothbrush and/or water flosser pursuant to your recommendation to treat or mitigate a medical condition you have diagnosed, your patient may be eligible for reimbursement or tax-preferred treatment under that FSA, HRA or HSA (subject to any additional limitations or conditions of the plan).

Patient

Mail or fax this form (and a copy of your receipt) to your FSA/HRA Administrator (or retain for your HSA records).

Completed by Patient

I certify that the expenses I am claiming are a direct result of the medical condition described below, and that I would not incur this expense if I were not treating or mitigating this medical condition.

Patient Name: _____

Participant Name: _____

Participant's Employer: _____

Member Number: _____

Diagnosis: _____

Completed by Patient

Philips Sonicare power toothbrush and/or water flosser used once daily for a period of no less than 30 days. This treatment is medically necessary to treat or mitigate the condition described above; it is not for general health and is not for cosmetic purposes.

Signature of Attending Dental Professional: _____ Date: _____

Printed Name (First & Last): _____

Address: _____

Telephone Number: (_____) _____ - _____

#XXXXXXX

PHILIPS
sonicare

Letter of Medical Necessity

Flex Spending Accounts (FSA) / Health Reimbursement Arrangement (HRA) / Health Savings Accounts (HSA)

Under IRS and CRA guidelines, some healthcare products are eligible for (a) reimbursement through an FSA/HRA, or (b) treatment as a tax-free distribution from an HSA only if it can be shown that the products are medically necessary. If a dental professional has diagnosed a medical condition and recommended a Philips Sonicare power toothbrush and/or water flosser as treatment or mitigation for the medical condition, under IRS guidelines it should qualify for reimbursement through an FSA/HRA and for tax-preferred treatment for an HSA. Some plans may restrict reimbursement beyond the IRS requirements. Dental professionals: If your patient participates in an FSA, HRA or HSA program, and they purchase a Philips Sonicare power toothbrush and/or water flosser pursuant to your recommendation to treat or mitigate a medical condition you have diagnosed, your patient may be eligible for reimbursement or tax-preferred treatment under that FSA, HRA or HSA (subject to any additional limitations or conditions of the plan).

Patient

Mail or fax this form (and a copy of your receipt) to your FSA/HRA Administrator (or retain for your HSA records).

Completed by Patient

I certify that the expenses I am claiming are a direct result of the medical condition described below, and that I would not incur this expense if I were not treating or mitigating this medical condition.

Patient Name: _____

Participant Name: _____

Participant's Employer: _____

Member Number: _____

Diagnosis: _____

Completed by Patient

Philips Sonicare power toothbrush and/or water flosser used once daily for a period of no less than 30 days. This treatment is medically necessary to treat or mitigate the condition described above; it is not for general health and is not for cosmetic purposes.

Signature of Attending Dental Professional: _____ Date: _____

Printed Name (First & Last): _____

Address: _____

Telephone Number: (_____) _____ - _____

#XXXXXXX