



TriNet SOI Health Care Flexible Spending Account Letter of Medical Necessity

Under federal rules, certain health care services and products are only eligible for reimbursement from a health care flexible spending account (FSA) or limited-expense health care FSA when a doctor, dentist, or other licensed health care provider certifies that they are medically necessary.

This form requests only the specific information needed to process your health care FSA claim. All information provided on this form will be treated by TriNet SOI with the utmost confidentiality and will only be used to adjudicate your health care FSA claim. TriNet SOI will not release health care FSA claim information to any other person unless you have signed a HIPAA release authorizing TriNet SOI to do so.

Once approved, this form is valid until the end of your current TriNet SOI Plan Year. TriNet SOI reserves the right to request an updated Letter of Medical Necessity at any time. Submittal of this form does not guarantee that the expense is eligible to qualify for health care FSA reimbursement under IRS guidelines.

Please do not use this form as a substitute for a prescription for over-the-counter (OTC) medications, as TriNet SOI cannot process a claim for OTC medications without a prescription. OTC medicines are eligible health care FSA expenses only if you obtain a prescription for the medicine or drug. A prescription is a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

TriNet SOI
P. O. Box 241448
Charlotte, NC
28224

Please complete,
sign, and fax this
form to TriNet SOI
at 877.723.0150.

To Be Completed by the Worksite Employee	
Patient Name	
Worksite Employee Name	
Last four digits of your social security number/TriNet SOI Employee ID	
Email Address	
I certify that these expenses will be incurred by me, and/or my spouse and/or eligible dependents. I understand that my provider has limited the duration of my treatment and I will not submit expenses beyond that limitation.	
Worksite Employee Signature	Date
To Be Completed by the Provider	
Diagnosis	CPT Code
Recommended Treatment	
How will the treatment alleviate the diagnosis?	
Expected duration of treatment (including start and end date)	
Provider Name	
Provider Address	
Provider License #	Provider Telephone #
Provider Signature	Date

**If you have questions, please contact the TriNet SOI Solution Center at 800.572.2412,
Monday–Friday, 7:30 a.m.–midnight ET, 4:30 a.m.–9 p.m. PT, or email SOI-FSA@TriNet.com**