



**THIS FORM CAN BE USED TO SUBSTANTIATE OTC MEDICINES AND/OR AS A LETTER OF MEDICAL RECOMMENDATION. PLEASE HAVE YOUR HEALTH CARE PROVIDER COMPLETE THE PART OF THE FORM THAT IS APPLICABLE TO YOUR CLAIM. All fields in the appropriate section must be completed. Use additional sheets if necessary.**

**Please provide the following information (please print clearly)**

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Employer Name: \_\_\_\_\_

**Over the Counter Medicine Prescription** (The IRS requires that all OTC Medicine be prescribed to be reimbursed tax free.)

**List the specific prescribed over the counter medications:**

\_\_\_\_\_  
\_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

License Number: \_\_\_\_\_ DEA No: \_\_\_\_\_

Address: \_\_\_\_\_

The Health Care Provider acknowledges that this is a Prescription lawfully issued according to the state law in which it was written. Please do not provide the DEA Number unless required on all prescriptions by state law.

**LETTER OF MEDICAL RECOMMENDATION** (e.g. Massage Therapy, Weight Loss Programs, Nutritionist Expenses) Unless otherwise noted by your physician, this form will expire after 1 year.

**Describe the diagnosed condition being treated:**

\_\_\_\_\_  
\_\_\_\_\_

**Describe the specific recommended treatment:** If vitamins/supplements are being recommended, your physician must specify each individual supplement needed to treat the medical condition listed.

\_\_\_\_\_  
\_\_\_\_\_

**Indicate the duration of treatment:**

\_\_\_\_\_  
\_\_\_\_\_

This treatment is recommended to treat the medical condition referenced above. This treatment is not for general health purposes, to improve the appearance or for cosmetic services.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_