

# MEDICAL NECESSITY REQUEST

Voya Benefits Company, LLC  
A member of the Voya® family of companies  
Customer Service: PO Box 1168, Minneapolis, MN 55440  
Phone: 1-855-483-3539; Fax: 1-603-232-1854; Email: HVDFlex@voya.com



Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by Voya Institutional Trust Company.

This form is to be completed when submitting “dual-purpose” expenses. Per Internal Revenue Service (IRS) regulations, dual-purpose expenses are only eligible if recommended by a medical practitioner, as they have both a medical purpose and a personal, cosmetic, or general health purpose. Complete and submit this form for any dual-purpose expense for which you are requesting reimbursement.

## STEP 1: ACCOUNT HOLDER INFORMATION

Consumer Name (Required) (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
Employer Name (Required) \_\_\_\_\_  
Birth Date (mm/dd/yyyy) (Required) \_\_\_\_\_ Harvard University ID (HUID) (Required) \_\_\_\_\_  
Daytime Phone (Required) \_\_\_\_\_ Email \_\_\_\_\_  
Permanent Address (Required) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

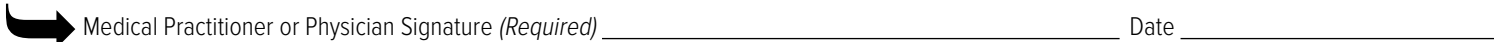
## STEP 2: CLAIM INFORMATION

Is this form being submitted for a previously denied claim? If neither box is selected, the form will be processed as “no”. (Required)  Yes  No

**If “yes,” provide the claim number(s) for which you are submitting this form. Failure to provide the appropriate claim number(s) will result in the Medical Necessity Request being added to your account (if approved) and previous claim denials not being reprocessed.**

Claim Number \_\_\_\_\_ Claim Number \_\_\_\_\_  
Claim Number \_\_\_\_\_ Claim Number \_\_\_\_\_

## STEP 3: MEDICAL PRACTITIONER INFORMATION

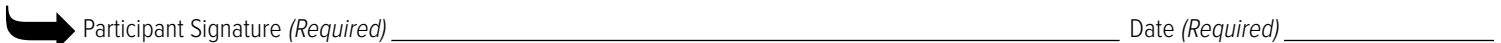
Name of and Type of Medical Practice (Required) \_\_\_\_\_  
Phone (Required) \_\_\_\_\_  
Medical Practitioner or Physician Name (Required) (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
 Medical Practitioner or Physician Signature (Required) \_\_\_\_\_ Date \_\_\_\_\_

## STEP 4: MEDICAL NECESSITY INFORMATION

Treatment Recipient Name (Required) (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
Medical Diagnosis or Diagnosis Code (Example: 724.2 (Lumbar Back Pain)) (Required) \_\_\_\_\_  
Treatment (Example: Massage Therapy) (Required) \_\_\_\_\_

## STEP 5: PARTICIPANT CERTIFICATION

I hereby certify that the reimbursement requests I am submitting are considered medically necessary and are IRS-eligible expenses. I also understand that Voya Financial, including its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement.

 Participant Signature (Required) \_\_\_\_\_ Date (Required) \_\_\_\_\_

**Mail or fax the completed form to:  
Voya Financial, PO Box 1168, Minneapolis, MN 55440; Fax: 1-603-232-1854.  
Questions? Call Customer Service at 1-855-483-3539.**