RESET FORM

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.