Horizon *MyWay*®

Medical Necessity Form

This form is to be completed when submitting "dual-purpose" expenses. Per 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.

Instructions:

1. Complete all sections of this form.
2. Securely email, mail or fax completed form to:
   Secure Email: HorizonMyWay@healthaccountservices.com
   Address: Horizon *MyWay*, PO Box: 2340, Fargo, ND 58108-2340
   Fax: (833) 710-5544
3. If you have any questions about completing this form, please contact Horizon *MyWay* Consumer Services at (877) 765-8811. We have representatives available Monday-Friday, 8:00 am to 8:00 pm EST.

Medical Necessity Form is only valid for 12 months from date of receipt

Step 1: Consumer Information

*Required Fields

*Consumer Name (First, MI, Last)

*Employer Name

*Birth Date (MM/DD/YYYY) / /

*Social Security Number - -

*Phone Number

*Permanent Address

Email Address

*City

*State

*Zip Code

Updates or changes to your information can be made by logging into your account at www.HorizonBlue.com

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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".**

☐ **Yes** ☐ **No**

If yes, please 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 Form 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 Medical Practice

*Phone Number - -

*Medical Practitioner or Physician Printed Name

*Medical Practitioner or Physician Signature

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Step 4: Medical Necessity Information

*Recipient of Treatment (First, MI, Last)

*Medical Diagnosis or Diagnosis Code

Example: 724.2 (Lumbar Back Pain)

*Itemized List of Treatment or Product

Example: Massage Therapy; Vitamin C Tablets

Step 5: Consumer Certification

I hereby certify that the reimbursement requests I am submitting are considered medically necessary and are IRS -eligible expenses. I also understand that Horizon *MyWay*, including its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I acknowledge that this form may be electronically signed and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

*Consumer Signature

*Date

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