Operating Engineers Local 139 Health Benefit Fund

P O Box 160, Pewaukee, WI 53072-0160, 262-549-9190 or toll free 800-242-7018, Fax 262.549.3549,
hra@iuoe139.org

Health Reimbursement (HRA) Letter of Medical Necessity

Participant Information (IUOE 139 member)

Print Participant's Last Name	First Name	OEF Number or SSN	
Address Street Number	City	State	Zip
Telephone Number	Email Address (a confirmation email will be sent from the Health Fund when this form is received)		

Under the IRS rules regarding HRA claims, some health care services and products are only eligible for reimbursement when a letter from your physician is received certifying the services are medically necessary and are not for general health or cosmetic reasons. Your physician needs to provide the medical condition being treated, the specific treatment needed, the length of treatment and explanation on how the treatment will alleviate your medical condition.

Physician Statement

Describe the recommended treatment (Must be specific). If recommending vitamins or herbs or exercise , list specific names :

Patient name: Diagnosis:

How will the treatment alleviate the diagnosed condition? :

Treatment time period (not to exceed 12 months) Start date _____ End Date _____

Physician Authorization (this form must be signed or it will be returned)

By signing below, I certify that treatment I am recommending is medically necessary to treat a specific medical condition as described above. The treatment is not in any way for general health and is not for cosmetic purpose to improve appearance.

_____ _____

Physician Signature Date

** this form must be signed or it will be returned **