Perfect Balance Day Spa

LETTER OF MEDICAL NECESSITY (HSA/FSA DOCUMENTATION)

Patient Information	Name _____ DOB _____ Phone _____ Address _____ _____
Healthcare Provider	Provider _____ Practice _____ Phone _____ Fax _____ NPI _____
Diagnosis / ICD-10	_____ _____
Recommended Services	■ Therapeutic Massage ■ Medical Massage ■ Lymphatic Drainage ■ Acne Treatment Facial ■ Rosacea Facial ■ Scar Therapy ■ Other _____
Frequency / Duration	■ One Time ■ Weekly ■ Every 2 Weeks ■ Monthly ■ Other _____ Length of Treatment _____
Medical Reason for Recommendation	_____ _____ _____ _____
Provider Certification	I certify that the above services are medically necessary for the treatment or management of the patient's diagnosed condition and are not prescribed solely for general wellness, relaxation, or cosmetic purposes. Provider Signature _____ Date _____ Printed Name _____
Patient Acknowledgment	I understand that my healthcare provider determines medical necessity and my HSA/FSA administrator makes the final determination regarding reimbursement eligibility. Perfect Balance Day Spa cannot guarantee reimbursement. Patient Signature _____ Date _____