

# TAXSAVER PLAN

## Medical Determination Form

*You may submit this completed form to TaxSaver Plan - via facsimile at 214-528-8122*

\_\_\_\_\_  
Patient Name:

\_\_\_\_\_  
Participant's Employer:

\_\_\_\_\_  
Participant's Name:

\_\_\_\_\_  
Participant's Social Security Number:

This form should be completed by the attending physician to confirm treatment is necessary to treat a specific medical condition or disease. This form may be used for specific treatments and dual purpose over the counter expenses. PLEASE NOTE THAT THIS FORM MUST ACCOMPANY THE RECEIPT AND WILL BE REVIEWED FOR ELIGIBILITY UNDER YOUR EMPLOYER'S PLAN. THE COMPLETION OF THIS FORM BY A DOCTOR DOES NOT GUARANTEE REIMBURSEMENT.

1. Describe the diagnosed medical condition or disease that requires treatment.
  
  
  
  
  
  
  
  
  
  
2. Describe the recommended treatment.
  
  
  
  
  
  
  
  
  
  
3. Indicate the length of the treatment.

This treatment is medically necessary to treat the specific medical condition or disease described above. This treatment is in no way for general health and is not for cosmetic purposes.

Please note that the duration of treatment must not exceed the end of your current plan year. We must have a current letter on file from your practitioner each active plan year for reimbursement consideration of your dual purpose expense.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address of Physician