Security Flex 125 Program®

Letter of Medical Necessity

Patient Name: ____

Participant Name: ____

Participant's Employer: ____

Participant SSN: ____

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition. Complete the following:

1. Describe the diagnosed medical condition being treated. (Include diagnosis code):

____

____

____

2. Describe the recommended treatment:

____

____

____

3. Indicate the duration of treatment:

____

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This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health; and is not for cosmetic purposes to improve appearance.

____________________________ ____________________
Signature of Attending Physician Date

____________________________ ____________________
Physician's Name Printed Phone Number

____
Physician's Address

____________________________ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___
City State Zip Code

Mail to: Security Benefit Life Ins. Co.
Employer Benefits Administration
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1-888-662-3646 • (785) 438-3000 • FAX (785) 438-3479