Your doctor, MD
practice name
practice address
address/state/zip

Re: patient name
DOB: xx / xx / xxxx

To Whom It May Concern:

This letter authorizes claim submissions for reimbursement under ----------your full name ---------- Flexible Savings Account or Health Savings Account.

Term of duration for this letter is the remainder of her lifetime.

Authorization is given for all OTC items eligible for reimbursement as noted under current guidelines. Changes to IRS rulings or interpretations for FSA, and/or legislative guidelines for HSA are included to be authorized unless otherwise informed.

Authorization is given for integrated health/complementary therapies including, but not limited to: energy therapies such as Healing Touch™; body work such as massage therapy or craniosacral therapy; personal exercise training by qualified personal trainer/exercise rehabilitation; mind body therapies such as clinical hypnosis and guided imagery, and targeted nutritional supplements.

These are part of a medical treatment plan for the above named patient.

If there are any questions regarding this matter, please do not hesitate to contact.

Sincerely,

Your doctor, MD