

# Medical Necessity Form - OTC & Dual Use

**Instructions:** Use this form as a substitute for a doctor's prescription or letter to prove a medical condition or need in order to make over-the-counter medicines and drugs or dual use expenses eligible for reimbursement in your employer's flexible benefits plan. For OTC, the doctor's instructions must comply with state prescription laws. Section 2 must be completed by the prescribing doctor or other licensed practitioner.

Please refer to your enrollment materials or SuperiorUSA's OTC List for a breakdown of eligible, ineligible, and dual use expenses. OTC equipment, supplies, and kits, do not require a prescription, letter, or this Form.

Your employer and SuperiorUSA reserve the right to question the eligibility of treatment in conjunction with IRS regulations. We may ask for additional documentation, whether or not the prescription, letter, or Medical Necessity Form appears valid and complete.

**SECTION 1: GENERAL INFORMATION** (Please Print)

Patient Name (Last, First, MI)	Relationship to Employee/Participant	Date of Birth	
Employee/Participant Name (Last, First, MI)	Employer	Last 4 Digits of SSN	Date of Birth
Medical Necessity Form Retention: <input type="checkbox"/> One time submission <input type="checkbox"/> Retain on file for the remainder of the plan year			

**SECTION 2: PRESCRIPTION INFORMATION** (Please Print)

<i>This section is to be completed by a doctor or other licensed practitioner (authorized to write prescriptions) ONLY. Multiple prescriptions or treatments may be prescribed in each section and together on one form.</i>		
<b>Medical condition:</b>		
<b>Medication, device, or treatment plan recommended:</b>		
<b>Optional - Duration of treatment (assumed remainder of the flex plan year unless specified):</b>		
<i>By signing below, you agree that this treatment is required or medically necessary to treat the specified medical condition and is not for the patient's general health or cosmetic reasons.</i>		
<b>Doctor/Practitioner's Signature</b>		<b>Doctor/Practitioner's Printed Name</b>
<b>Phone</b>	<b>Medical Practice/Facility</b>	<b>Date</b>

Completed forms must be submitted along with claim forms and supporting documentation directly to SuperiorUSA for reimbursement. Forms may be faxed (218-725-9161 or 877-422-5192) or mailed to our address. Please visit our website at [www.superiorusa.com](http://www.superiorusa.com), email, or call (877) or (218) 529-2477 with questions.

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