IRS-Compliant Documentation Requirements for Claim Approval

To ensure your healthcare claim is accepted and processed according to IRS guidelines, it is essential to submit appropriate documentation. The IRS requires specific details to verify that an expense is eligible for reimbursement through tax-advantaged accounts such as FSAs, HRAs, ICHRA, and more.

Required Documentation Must Include:

For **each claim**, the following information must be clearly listed on your documentation (typically an itemized invoice or Explanation of Benefits [EOB]):

1. Provider Name
    a. The name of the doctor, hospital, pharmacy, or service provider.
2. Patient Name
    a. The individual who received the service or treatment.
3. Date of Service
    a. The actual date(s) when the medical service or product was provided.
4. Service Description
    a. A brief but clear description of the medical service, product, or procedure (e.g., “general physical exam,” “prescription medication,” “physical therapy”).
5. Breakdown of Charges
    a. The cost of each service or product provided, with any insurance payments or adjustments shown if available.

TIP: A credit card receipt alone is **not** sufficient for IRS documentation. The documentation must clearly show *what* service or product was received and *why*.

SUBSCRIBER: JAMIE JONES
PATIENT: JAMIE S JONES
PROVIDER: NORTH SHORE FAMILY DENTISTRY (012345678)
ID NUMBER: 012345678910
CLAIM NUMBER: 123545678910
Email: jamie.jones@gmail.com
Page: 1 of 5
Date: 05/16/19

PROCEDURE DESCRIPTION PROCEDURE CODE *TOOTH DESCRIPTION*	SERVICE DATE(S)	PROVIDER CHARGE	ALLOWED AMOUNT	AMOUNT PAID	AMOUNT NOT PAID	REMARKS
PERIODIC EVALUATION D0120	05/08/19	54.00	23.72	23.72	30.28	Q1030
PROPHYLAXIS ADULT D1110	05/08/19	95.00	46.16	46.16	48.84	Q1030
BITEWINGS FOUR FILMS D0274	05/08/19	64.00	28.35	28.35	35.65	Q1030
	TOTALS	213.00	98.23	98.23	114.77	

When a Letter of Medical Necessity is Required:

In some cases, certain healthcare expenses are only reimbursable if a **Letter of Medical Necessity (LMN)** is provided. This is a formal document from your licensed healthcare provider stating that a product or service is required to treat a specific medical condition. The IRS requires this documentation for any expense that **might be considered general health or personal wellness** (like massage therapy, supplements, or special equipment).

This letter must include the following:

- **Patient Information** (your full name and date of birth)
- **Provider Information** (doctor’s full name, credentials, and contact information (on their official letterhead))
- **Medical Condition** (the diagnosed condition being treated, including the ICD-10 diagnosis code, if available)
- **Treatment/Product Being Recommended** (clearly state the service, item, or product (e.g., “acupuncture”))
- **Medical Necessity Explanation** (why this service/item is medically necessary and how it will help alleviate symptoms, treat the condition, or prevent worsening)
- **Recommended Duration** (how long you will need the treatment (e.g., “twice weekly for 6 months”))
- **Provider Signature and Date** (the letter must be signed and dated by the provider)

Sample Request You Can Send to Your Provider:

“Hi [Doctor’s Name],

I’m submitting a healthcare expense for reimbursement and need a Letter of Medical Necessity per IRS guidelines.

Could you please write a letter on your official letterhead that includes my diagnosis, why [product/service] is medically necessary, and the recommended duration? Thank you!”

MEDSURETY
Health Savings

SAMPLE 'LETTER OF MEDICAL NECESSITY'

[Physician's Letterhead]

[Date]

[Name of Pharmacy Director/Payer Contact]
[Contact Title]
[Name of Health Insurance Company]
[Address]
[City, State, ZIP Code]

RE: Coverage for [Product Name]

Patient: [Patient Name]
Date of Birth: [Date]
Diagnosis: [Diagnosis], [ICD-10-CM]
Group/Policy Number: [Number]
Policyholder: [Policyholder Name]

Dear [Pharmacy Director/Payer Contact Name]

I am writing on behalf of my patient, [Patient Name], to document the medical necessity to treat their [Diagnosis] with [Product Name].

This letter serves to document my patient's medical history and diagnosis and to summarize my treatment rationale. Please refer to the [List of Enclosures] enclosed with this letter.

Summary of Patient's Medical History and Diagnosis
[Patient Name] is [Age] years old and was initially diagnosed with [Diagnosis] [ICM-10-CM] on [Date]. [Patient Name] has been in my care since [Date].

[Provide a discussion of the patient's clinical history, current symptoms and condition, any potential contraindications, and any relevant laboratory test results, highlighting the factors leading you to recommend use of the product.]

Rationale for Treatment
[Include your clinical rationale and reasons for prescribing the product.]

In summary, [Product Name] is medically necessary and reasonable to treat [Patient's Name] [Diagnosis], and I ask you to please consider coverage of [Product Name] on [Patient Name's] behalf. Please refer to the enclosed supporting documents for further details, and do not hesitate to call me at XXX-XXX-XXXX if you have any questions or if you require additional information.

Thank you for your attention to this matter.

Sincerely,

[Prescribing Physician Name and Credentials]
[NPI Number]

Enclosures: [List any Enclosures, such as: Prescribing Information, Medication Guide, and Clinical Notes and Records]