SECURITY BENEFIT®

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:

_____

_____

_____

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
PO Box 750600 • Topeka, Kansas 66675-0600
1-800-888-2461 • Fax 1-866-477-6526