MAIL TO:
Corporate Planning Network, Inc.
P.O. Box 1748
Cordova, TN 38088
(901)756-8244

E-MAIL/FAX TO:
Corporate Planning Network, Inc.
(1) claims@cpnflex.com
(2) 901-756-8322
(No Cover Page Required)

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***

_____
Print Name

Address: _____ **Phone:** _____

_____