



Statement of Medical Necessity

Date

Patient name

Please note, by way of this statement, I have recommended the following services:

For treatment of the following medical condition(s):

Duration of treatment

From To

Signature of Licensed Medical Practitioner:

Printed name:

Address:

Phone:

Fax to: Benefit Managers Company
208-672-8330 / 1-888-672-8330
Phone: 208-322-6546