Surency FLEX

LETTER OF MEDICAL NECESSITY

Complete this form if you have received a denial from Surency requesting this letter or if you are completing a Capital Expense Worksheet. **NOTE: Physician's signature is required**.

Member Information:

Last Name, First Name, MI (Please Print) _____

Employer _____

Social Security or Employee ID _____

Street Address _____

City, State, ZIP _____

Services Provided To: _____
Last Name, First Name, MI (Please Print)

Effective/Start Date of Treatment: _____

Specific Medical Condition:

Treatment: *(that is considered medically necessary to treat, prevent or alleviate the specific medical condition)*

Length of Time for Necessary Treatment:

Physician's Signature: *(required)*

Physician's Name _____

Physician's Address _____

City, State, ZIP _____

Physician's Signature _____

Date _____

Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773

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