OPTUM Financial™

Letter of Medical Necessity Form

Form Instructions: Under Internal Revenue Service (IRS) rules, certain expenses are eligible for health care account reimbursement only when accompanied by a Letter of Medical Necessity. When required, submit this completed form with your claim submission as additional documentation. ***Please keep a copy of all submitted documents for your records.***

Note: If a claim requires a Letter of Medical Necessity, the claim will not be paid until the Letter of Medical Necessity Form and any required supporting documentation is received. An updated Letter of Medical Necessity is required each year. This form is valid for one year from the date of signature. This form is subject to review and does not have guaranteed approval.

Account Holder Name

Patient Name (if different from Account Holder Name)

See following pages for required treatments

To be completed by physician:

Describe the diagnosed medical condition being treated: See following pages for medical conditions

Describe the required treatment:

This treatment is medically necessary to treat the specific medical condition noted above. This treatment is not in any way for general health; and is not for cosmetic purposes to improve appearance.

Provider Signature

Date

Provider Name (Please Print)

Provider License #

Provider Telephone Number

How to Submit: Account holder should include this completed form with claim request, using your preferred claim submission method (online, mobile, or fax).

LETTER OF MEDICAL NECESSITY

November 16, 2025

To: HSA/FSA Administrator

From: Derek Yan, MD

Subject: Letter of Medical Necessity for adsf fasdf

1. REPORTED DIAGNOSIS

Anxiety and Depression with Chronic Pain risk

2. TREATMENT RECOMMENDATION

The patient is recommended to undergo regular massage therapy sessions at Tension Intervention. The treatment plan includes twice-monthly 60-minute therapeutic massage sessions focusing on myofascial release techniques, trigger point therapy, and Swedish massage methods. These sessions will specifically target areas of muscle tension that exacerbate anxiety symptoms and contribute to pain patterns. The therapist at Tension Intervention will document progress after each session, adjusting techniques as needed to address the patient's evolving symptoms as part of the management plan for 12 months.

3. CLINICAL RATIONALE

The patient presents with diagnosed anxiety (F41.9) and depression (F32.9), with a family history of depression and chronic pain, placing her at elevated risk for developing chronic pain conditions herself. Research has demonstrated that massage therapy is an effective complementary treatment for both anxiety and depression. A systematic review (PMID: 28891221; Field T, 2016) found that massage therapy significantly reduced anxiety and depression symptoms through multiple physiological mechanisms, including reduced cortisol levels and increased serotonin and dopamine. Additionally, regular massage therapy at Tension Intervention can help prevent the development of chronic pain by addressing muscle tension patterns before they become persistent pain conditions. The patient's expressed desire to 'be healthier' aligns with this preventive approach.

4. ROLE THE SERVICE PROVIDES

Tension Intervention's massage therapy services provide a non-pharmacological intervention that reduces physiological markers of stress, decreases muscle tension, and improves mood regulation to complement standard treatments for anxiety and depression.

5. CONCLUSION

Given the patient's diagnosed conditions of anxiety and depression, family history of chronic pain, and the substantial clinical evidence supporting massage therapy's efficacy for these conditions, the requested massage therapy services at Tension Intervention are medically necessary as part of the patient's comprehensive treatment plan.

6. PRODUCTS AND/OR SERVICES RECOMMENDED

Massage Therapy from Tension Intervention

Intervention Start Date: November 16, 2025 **Intervention End Date:** November 16, 2026

PROVIDER INFORMATION

Provider Name: _____ Provider Address: _____

Provider Phone Number: _____ Provider Email: _____

Provider License: _____ License State: _____

Sincerely,

_____

November 16, 2025