Subject: Letter of Medical Necessity form for your HSA or FSA

Attached is a Letter of Medical Necessity form for your physician to complete and sign for your Equiscope sessions. If your HSA or FSA plan asks for documentation, this form plus your itemized receipts is usually what they want.

Please bring or send the attached form to your treating clinician (MD, DO, NP, or PA). Once it is signed, keep a copy for your records and submit it to your plan administrator if they request it.

If you want, send me a photo of the signed form and I will make sure your receipts match the dates and wording your plan typically looks for.

Thanks,
Jen Guidry Fassler
SA Pain Relief | Hill Country Pain Therapy
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LETTER OF MEDICAL NECESSITY

Equiscope Sessions (Microcurrent Therapy)

Patient Name: _____
Date of Birth: _____
Patient ID (optional): _____

Treating Clinician Name and Credentials: _____
Practice/Clinic Name: _____
Phone: _____ **Fax (optional):** _____
NPI (optional): _____ **State License #:** _____

Date: _____

Medical Necessity Statement

I am the treating clinician for the patient listed above. Based on my evaluation and ongoing care, I am recommending **Equiscope (microcurrent therapy) sessions** as part of the patient's treatment plan to address a medical condition and/or related symptoms. This service is recommended for the **treatment/mitigation of symptoms** and/or to **affect a structure or function of the body**.

Condition and Symptoms (check all that apply)

Primary diagnosis/condition (ICD-10 if available): _____

Symptoms/functional issues being treated:
☐ Acute or chronic pain
☐ Inflammation
☐ Musculoskeletal injury / soft tissue injury
☐ Neuromuscular dysfunction
☐ Headaches / migraines
☐ Post-surgical recovery support
☐ Neurological symptoms / concussion recovery support
☐ Autonomic dysregulation (stress response imbalance)
☐ Anxiety symptoms with physiological dysregulation
☐ Sleep disruption related to pain/stress physiology
☐ Other: _____

Requested Treatment

Recommended service: Equiscope (microcurrent therapy) sessions
Frequency: ____ sessions per week / month
Duration: From _____ through _____ (or ____ weeks/months)

Medical Rationale (brief)

_____

_____

_____

Statement for Plan Administrator

This service is recommended as part of the patient's medical care. The patient may submit this letter with itemized receipts for consideration of reimbursement through a Health Savings Account (HSA) or Flexible Spending Account (FSA), subject to their plan rules.

Clinician Signature: _____ **Date:** _____
Printed Name: _____
Credentials: _____