

Please attach the required documentation to your claim form and send to:

Stanley Benefits, Inc.
Post Office Box 29329
Greensboro, NC 27429-9329

Fax Number 1-877-432-9247 Number of pages _____
OPTIONS FOR OBTAINING ACCOUNT INFORMATION
Website: www.stanleymail.com (pin # required)
Phone: 1-877-SBS-FLEX (1-877-727-3539)

MEDICAL DETERMINATION FORM

(PRE-PAYMENT OF SERVICES IS ALLOWED ONLY FOR PREGNANCY AND ORTHODONTIA)

Patient Name: _____

Participant Name: _____

Participant's Employer: _____

Participant's SSN: _____

This form should be completed by the attending physician to confirm treatment is medically necessary for a **specific medical condition**. Complete the following:

1. Describe the diagnosed medical condition being treated. (include diagnosis and ICD codes)

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 or relieve stress.

Attending Physician's Signature

Date

PLEASE PRINT:

Physician's Name: _____

Address: _____

Telephone: _____