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)

Specific Medical Condition

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

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Length of Time for Necessary Treatment

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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

866-818-8805 | Surency.com

Surency Flex is administered by Surency Life & Health Insurance Company.
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