PRESCRIPTION ORDER FORM

INSTRUCTIONS

1) Use this form to be reimbursed for healthcare products and services that require physician authorization such as Massage Therapy and Exercise Equipment.
2) Complete the form on the following page:
    a. Complete **Section I** (including your signature and the date) and **Section II** (Patient Name, Treatment Prescribed, and Reason for Treatment) *prior* to visiting your Medical Practitioner.
    b. Bring this form with you to your next medical appointment and request that the attending Medical Practitioner complete **Section II** (**Instructions/Restrictions**) and **Section III**.

    Instruct them to follow the specific pharmacy/prescription laws in their respective state when completing the Instructions/Restrictions portion (Section II).
3) You may use the same form for each individual in your household for whom you purchase healthcare expenses, as long as the same Medical Practitioner is completing the form
4) TASC FSA and TASC HRA Participants must submit a copy of this completed form to TASC with each Request for Reimbursement (if submitting online, include a copy with your receipts).
    a. Any *Prescription Order Forms* received without a Request for Reimbursement will not be processed.
    b. AgriPlan and BizPlan participants should retain the completed form for their own records.

DEFINITIONS *(for the purposes of this form)*

1) "Medical Practitioner" generally includes the following health professionals: physician (MD/DO), physician assistant, nurse practitioner, dentist, optometrist and podiatrist.
2) "Prescription Order" is any order for medical services or products signed by a licensed medical practitioner granted prescriptive authority by the laws of the state. It contains the name, and quantity of the medicine/product/service prescribed, directions for use, and treatment duration.

Products and services that require a Prescription Order Form or other physician authorization to show the expense is to treat a medical condition include the following:

Air Purifier	Exercise Equipment	Orthopedic Shoes (excess cost only)
Varicose Vein Treatment	Automobile Modifications	Massage Therapy
Special Foods (excess cost only)	Whirlpool/Spa	Ear Plugs
Nutritionist's Professional Fees	Support Hose	Wigs

***STATE RESTRICTIONS:**

The Medical Practitioner's signature may NOT be pre-printed in the states of: Arkansas, Connecticut, Florida, Georgia, Idaho, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Virginia, and Washington.

The use of this form is prohibited; a prescription is required in: Montana, Pennsylvania, and South Dakota.

PRESCRIPTION ORDER FORM

Please complete and sign this order form per the instructions on the previous page and submit to TASC.
For assistance with this form: call toll-free 800-422-4661 and have your Client ID# ready.

SECTION 1

Employer (Company) Name:	
Participant (Employee) Name:	
Participant TASC ID# (if known):	

The statements on this document are complete and true, to the best of my knowledge and belief. I understand that the IRS regulates my employee benefits account and that the guidelines are implemented as a means of ensuring compliance. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests.

_____ _____

Participant's Signature **Date**

SECTION 2

	Patient #1	Patient #2	Patient #3
Patient Name:			
Date of Onset: (mm/dd/yy)			
Reason for Treatment:			
Prescribed Treatment Products/Services:			
Prescribed Treatment Duration End Date:			
Instructions/Restrictions *(if applicable)*:			

SECTION 3 - AUTHORIZATION

I hereby certify that the treatment plan(s) listed above is/are medically necessary to treat the ailment or medical condition (listed next to Reason for Treatment). This treatment plan is neither for cosmetic reasons, nor for general health and well-being.

_____ _____

Name of Medical Practitioner (PLEASE PRINT) **State of Prescriptive Authority**

_____ _____

Medical Practitioner SIGNATURE **Date**