STANLEY BENEFITS
Leadership. Vision. Results.

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

Stanley Benefits, Inc.
Post Office Box 8249
Greensboro, NC 27419-0249

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

MEDICAL DETERMINATION FORM

Patient Name: _____

Participant Name: _____

Participant's Employer: _____

Participant's Last 4 digits 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: _____