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

_____

_____

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

_____

_____

_____

_____

Length of Time for Necessary Treatment

_____

_____

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