

## Physician Statement

FAX: (603) 6474668 Address: PO Box 1300, Manchester, NH 03105 300 E-Mail: Flexdept@benstrat.com

Employee Name		Employer:
Patient Name:		
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		ans may NOT be used for general health but only VHDVHµ \$QHZVWDWHPHQWZLOC ot guarantee reimbursement.
	Not to be used for	OTC Prescriptions
Condition being treated:		
Treatment plan :		
Length of treatment:		
Description of how treatment plan treats the specific condition:		
I certify that the above tre	atment is being prescribed to cure above and is med	e, alleviate or mitigate the medical condition listed lically necessary.
Physician Signature:		Date:
Print Physician Name:		
Practice Name:		
Contact Information:		
Practice Address:		
City:	State:	Zip Code: