

Instructions

1. Complete the Letter of Medical Necessity if you have received a denial from the Taben Group requesting this letter or if you are completing a Capital Expense Worksheet.
2. **Physician's signature is required.**
3. Fax completed form to 316.462.3392 OR forward to:
The Taben Group
C/O Surency Life & Health
PO Box 789773
Wichita, KS 67278-9773
www.taben.com
4. If you have any questions regarding this form, please call 855.826.8692.

Accountholder Information

_____	_____	_____
Last Name, First Name, MI (Please Print)	Employer	Social Security Number or Employee ID (EID) as appropriate
_____	_____	
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 specified medical condition

Length of Time for Necessary Treatment

_____	_____
Physician's Name	Physician's Address

	City, State, Zip
_____	_____
Physician's Signature (Required)	Date

