Notice of Personal Information

The following notice is provided in accordance with Section 559.003(a) of the Texas Government Code:

1. **With few exceptions, you are entitled on your request to be informed about the information The University of Texas System Administration collects about you;**
2. **Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information; and**
3. **Under Section 559.004 of the Texas Government Code, you are entitled to have The University of Texas System Administration correct information about you that is held by The University of Texas System Administration and that is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32, *Texas Public Information Act*.**

The information that The University of Texas System Administration collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.

MAIL TO:
PayFlex Systems USA, Inc.
Flex Dept.
P.O. Box 3039
Omaha, NE 68103-3039
Toll-Free (866) 887-3539

UT FLEX
LETTER OF
MEDICAL NECESSITY

FAX TO:
PayFlex System USA, Inc.
Flex Dept.
Toll-Free (877) 230-4283
(No Cover Page Required)
Page 1 of _____

Patient Name: _____

Employee Name: _____

Employee SSN: _____

Employer Name: _____

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition. Complete the following:

1. Describe the diagnosed medical condition being treated (include diagnosis code):

_____

_____

_____

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.

_____

Signature of Attending Physician ***Date***

_____

Print Physician Name

Address: _____ Phone: _____

_____