Letter of Medical Necessity

This letter serves as a prescription and letter of medical necessity for the patient referenced below currently being treated for obesity or overweight with one or more health consequences.

To be filled out by patient:

Patient Name:	
Sex:	
DOB:	
Address:	
Phone:	
SS#:	
Physician:	
Phone:	
Fax:	

To be filled out by physician regarding patient listed above:

Date:	
Height:	
Weight:	
BMI:	
BMI Weight Class:	Normal Overweight Obese Extremely Obese
I refer this patient because of diagnosis of...	___ Morbid Obesity ___ Obesity ___ Hypercholesterolmeia ___ Type 2 Diabetes ___ Sleep Apnea ___ Impaired Glucose Tolerance ___ Mixed Hyperlipidemia ___ Hypertension ___ Other (list)

Physician Comments:

Physician Signature: _____ Date: _____

Patient should keep this letter for tax purposes for proof necessary for reimbursement under a FSA, HRA, or Health Insurance Coverage Plan.