Letter of Medical Necessity

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

Patient Name:	
Sex:	
Date of Birth:	
Address:	
Phone:	
SS#:	
Physician's Name:	
Phone/Fax:	

To be filled out by physician regarding patient listed above:

Date:	
Height:	
Weight:	
BMI:	
BMI Weight Class:	____Normal ____ Overweight ____Obese ____ Morbidly Obese
I refer this patient due to the diagnosis of:	___ Morbid Obesity ___ Obesity ___ Hypercholesterolemia ___ Diabetes (II) ___ 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 HAS, FSA, HRA or Health Insurance Coverage Plan.