Weight Loss for Health, LLC mnolte@weightlossforhealth.com 402-957-1417

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:	
Date of Birth:	
Address:	
Phone:	
Social Security Number:	
Physician:	
Physician's Phone:	
Physician's 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 ___ Type 2 Diabetes ___ Mixed Hyperlipidemia	___ Obesity ___ Sleep Apnea ___ Hypertension	___ Hypercholesterolemia ___ Impaired Glucose Tolerance ___ Other (list)

Physician Comments:

Physician Signature: _____

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