

Letter of Medical Necessity

Health Care Flexible Spending Account / Health Savings Account

Insurance Reimbursement

Date:	Employer Name:
Employee Name:	SSN/FSA ID:
Patient Name:	Relationship to Employee:
Height:	Weight:
	BMI:
BMI Calculator: Normal Weight: 18.5 – 24.9; Overweight: 25 – 29.9; Obese: 30 – 39.9; Extreme Obesity: 40+	
Diagnosis: Patient is overweight or obese and has the following weight related medical condition(s): <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Other (describe below) <input type="checkbox"/> Pre Diabetes <input type="checkbox"/> Metabolic Syndrome <input type="checkbox"/> Chronic Joint Pain <input type="checkbox"/> Obesity	Recommended Treatment: I recommend a behavioral based weight loss regimen/program focused on a healthy diet and increasing physical activity. How will treatment alleviate the diagnosis? 5-10% weight loss has been shown to improve [this/these] clinical condition[s] and other associated risk factors.
	Duration of treatment required:
[MAY USE STAMP IN LIEU OF INFORMATION BELOW]	SERVICE PROVIDER STAMP
Service Provider Name:	
Service Provider signature:	
Service Provider License # and State:	
Address:	
City:	State:
Zip Code:	
Phone Number:	