Letter of Medical Necessity

Health Care Flexible Spending Account / Health Savings Account

Insurance Reimbursement

<table>
<tr><td>Date:</td><td>Employer Name:</td></tr>
<tr><td>Employee Name:</td><td>SSN/FSA ID:</td></tr>
<tr><td>Patient Name:</td><td>Relationship to Employee:</td></tr>
<tr><td colspan="2">Height: Weight: BMI:

BMI Calculator: Normal Weight: 18.5 – 24.9; Overweight: 25 – 29.9; Obese: 30 – 39.9; Extreme Obesity: 40+</td></tr>
<tr><td rowspan="2">Diagnosis:

Patient is overweight or obese and has the following weight related medical condition(s):

__ Type 2 Diabetes ____ Other (describe below)

__ Pre Diabetes

__ Metabolic Syndrome

__ Chronic Joint Pain

__ Obesity</td><td>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.</td></tr>
<tr><td>Duration of treatment required:</td></tr>
<tr><td>[MAY USE STAMP IN LIEU OF INFORMATION BELOW]

Service Provider Name:</td><td rowspan="8">SERVICE PROVIDER STAMP</td></tr>
<tr><td>Service Provider signature:</td></tr>
<tr><td>Service Provider License # and State:</td></tr>
<tr><td>Address:</td></tr>
<tr><td>City: State:</td></tr>
<tr><td>Zip Code:</td></tr>
<tr><td>Phone Number:</td></tr>
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