DARA TOMASSON

love yourself thin

Letter of Medical Necessity

This letter serves as a letter of medical necessity/prescription for the patient who is being treated through my program for obesity or being overweight with health consequences

To Be Filled Out by Patient:

Name _____

Gender _____

DOB _____

Address _____

Phone Number _____

Social Security Number _____

Physician _____

Phone _____

Fax _____

To Be Filled Out by Physician For the Above Mentioned Patient:

Date _____

Height _____

Weight _____

BMI _____

I refer this patient to this program because of this diagnosis:

Physician Comments:

Physician Signature:
Date:

Patient should keep this letter for tax purposes or for proof necessary under an FSA/HRA or Health Coverage Insurance Plan