Letter of Medical Necessity

Health Care Flexible Spending Account / Health Reimbursement Account / Health Savings Account Insurance Reimbursement

Date:	**Employer:**
Patient Name:	**SSN/FSA ID:**
Age:	**Employee:**
Height:	**Relationship:**
Weight:	
BMI:	

Diagnosis:

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

Recommended Treatment:

I recommend a behavioral based weight loss regimen/program focused on a healthy diet and increasing physical activity with Up For It Coaching & Fitness

How will treatment alleviate the diagnosis?

Weight loss has been shown to improve [this/these] clinical condition[s] and other associated risk factors.

Service Provider Name:	**Service Provider Signature:**
Service Provider License #:	**Address:**
City:	**State:**
Zip Code:	**Phone Number:**