LETTER OF MEDICAL NECESSITY

WEIGHT LOSS: www.PlanZDiet.com

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 and related co-morbidities.

To be filled out by patient:

Patient Name _____ Sex _____ DOB _____

Address _____ _____ Phone _____

City/State/Zip _____ SS# _____

Physician _____ Phone _____ Fax _____

To be filled by physician regarding patient listed above:

DATE	HEIGHT	WEIGHT	BMI	BMI Weight Class[1] (check one)
				____ Normal (18.5 – 24.9) ____ Overweight / Pre-obese (25.0 – 29.9) ____ Obese (30.0 – 39.9) ____ Extremely Obese (40.0 +)

Physician Order: I refer this patient to be on the Plan Z Diet weight loss program.

Diagnoses [2][3] (check all that apply)

____ Congestive Heart Failure	____ Obesity	____ Hypercholesterolemia
____ Morbid Obesity	____ Sleep Apnea	____ Coronary Atherosclerosis
____ Type 2 Diabetes	____ Hypertriglyceridemia	____ Impaired Glucose Tolerance
____ Mixed Hyperlipidemia	____ Hypertension	____ Other (list):

Physician Comments

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Physician Signature _____ Date _____

THANK YOU!

Patient should keep this letter for tax purposes for proof necessary for reimbursement under a Flexible Spending Account, Health Reimbursement Account, or Health Insurance Coverage Plan.

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[1] The International Classification of adult underweight, overweight and obesity according to BMI. WHO 2004.
[2] Centers for Disease Control and Prevention, International Classification of Diseases. Ninth Revision (ICD-9).
[3] NIH. Clinical Guidelines on the identification, evaluation, and treatment of overweight and obesity in adults - the evidence report. Obes Res. 1998;651S-209S.