LETTER OF MEDICAL NECESSITY FOR WEIGHT LOSS

PRESCRIPTION FOR CHANGE

Patient Name ______________________________

This patient is diagnosed with ______________________________

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This patient has a Body Mass Index of ______________________________

I REFER THIS PATIENT TO WEIGHT WATCHERS® FOR WEIGHT LOSS.

Physician's Comments ______________________________

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Physician's Signature ______________________________ *Date* ______________________________

PATIENT MUST KEEP THIS LETTER FOR TAX PURPOSES OR REIMBURSEMENT VIA A MEDICAL SAVINGS ACCOUNT, FLEXIBLE SPENDING ACCOUNT, OR HEALTH REIMBURSEMENT ARRANGEMENT.

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