LETTER OF MEDICAL NECESSITY FOR WEIGHT LOSS

PRESCRIPTION FOR CHANGE

Patient Name_____

This patient is diagnosed with _____

_____

This patient has a Body Mass Index of_____

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

Physician's Signature _____ Date _____

Physician's Comments_____

_____

_____

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