Date: _____

RE: Letter of Medical Necessity for No BS Weightloss Program for FSA/HSA reimbursement

To whom it may concern,

This letter is written to provide information about the membership of _____ who started our weight loss program on _____, 20_____.

The No BS Weightloss Program is a weightloss program and monthly membership subscription. Members are charged a recurring monthly membership fee of $59 for the No BS Success Path Program and entry services.

As a Certified Master Weight and Life Coach from The Life Coach School, I've created The No BS Weightloss Program to teach women how to lose both their physical and mental weight. The focus is on learning how to eat according to your body and how to change your relationship with food.

The courses provided help women to lose weight through:

- realistic planning
- listening to their physical hunger sensations
- prioritizing sleep and water
- and redefining their view on their ability to lose weight.

For information about our program, visit www.nobsweightloss.com/fsa-and-insurance/.

Sincerely,

CORINNE CRABTREE
Founder & CEO

NO BS WEIGHTLOSS PROGRAM

Letter of Medical Necessity

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.

To be filled out by patient:

Patient Name:	
Sex:	
DOB:	
Address:	
Phone:	
SS#:	
Physician:	
Phone:	
Fax:	

To be filled out by physician regarding patient listed above:

Date:	
Height:	
Weight:	
BMI:	
BMI Weight Class:	Normal Overweight Obese Extremely Obese
I refer this patient because of diagnosis of...	___ Morbid Obesity ___ Obesity ___ Hypercholesterolmeia ___ Type 2 Diabetes ___ Sleep Apnea ___ Impaired Glucose Tolerance ___ Mixed Hyperlipidemia ___ Hypertension ___ Other (list)

Physician Comments:

Physician Signature: _____ Date: _____

Patient should keep this letter for tax purposes for proof necessary for reimbursement under a FSA, HRA, or Health Insurance Coverage Plan.