LETTER OF MEDICAL NECESSITY

Flexible Spending Account/Health Savings Account

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To be filled out by licensed practitioner:

Medical Condition:

☐ Overweight / Obesity ☐ Type 2 Diabetes ☐ Heart Disease

☐ Hypertension ☐ Hyperlipidemia ☐ Sleep Apnea

☐ Osteoarthritis ☐ Other: ________________________________

Recommended duration of weight loss treatment:

☐ 12 months ☐ 6 months ☐ Other: ____

Physician's Comments:

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I refer _______________________________ to Profile by Sanford for weight loss.

(Patient Name)

Physician's Signature: ____Date: ____________________

Print Physician Name: ____

Clinic: ____

City, State, Zip: ____

Phone Number: _____________________