

# SWORKIT HEALTH

This form serves as a letter of medical necessity for the referenced patient in the management and treatment of obesity with other health consequences and co-morbidities, and/or musculoskeletal injury or disorders. I feel the following are accurate with respect to the referenced patient engaging in a comprehensive physical training and/or weight management program:

\_The service or benefit will, or is reasonably expected to, prevent the onset of an illness, or disability related to clinical obesity and/or musculoskeletal injury or disorders.

\_The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of clinical obesity and/or musculoskeletal injury or disorders.

## Patient Information

Filled out by patient:		
Patient Name:		
Address:		
City/State/Zip:		
Sex:	DOB	SSN:
Physician:	Phone:	Fax:

Filled out by physician:				
Date:	Height	Weight	BMI	BMI Classification: Normal (18.5-24.9) Overweight (25.0-29.9) Obese (30.0-39.9) Morbidly Obese (40.0+)
Additional Diagnosis of Consequence in Referral to Comprehensive Weight Management Program				(Check all that apply)
<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Mixed Hyperlipidemia	<input type="checkbox"/> Impaired Glucose Tolerance		
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Coronary Atherosclerosis		
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Musculoskeletal Injury or Disorder		
<input type="checkbox"/> Hypertriglyceridemia	<input type="checkbox"/> Coronary Atherosclerosis	<input type="checkbox"/> Other (please list):		

Physician Comments:	
Signature:	Date

Your medical care provider must complete this Letter of Medical Necessity.

Note: In order for the expense referred to on this Letter of Medical Necessity to be reimbursed, you must attach the receipt and claim form (additional requirements may vary). Documentation must include the date of service, the services rendered or product purchased, and the person for whom the services were rendered and the amount charged. Check with your benefits administrator to confirm eligibility of reimbursement. Sworkit Health does not guarantee reimbursement or accept responsibility for assumption of coverage.