

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 Comments _____

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.**