Letter of Medical Necessity

Patient Name: ____________________

Participant Name: ____________________

Participant Employer: ____________________

To be filled out by licensed practitioner:

Medical Condition: ____________________

I refer ____________________
Patient's Name

to Balance365 for weight loss / nutrition / health support.

Physician's Comments: ____________________

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Physician's Name: ____________________

Physician's Signature: ____________________

Date: ____________________

Go to www.balance365.com for more info

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