

Certificate of Medical Necessity for Backus Medical Weight Loss and Wellness Program
Directions: Please complete all sections, attach insurance information and fax to 860-889-4708

Section		
1	Demographics	Patient Name: Date of Birth: Address: Telephone: Emergency Contact: Telephone:
As the health care provider treating this beneficiary's obesity condition, I certify that Medical Weight Loss Program is needed under a comprehensive plan for this patient's obesity to ensure therapy compliance and/or to provide the necessary skills and knowledge to enable the patient to manage his/her condition. This patient is medically cleared to participate in the Backus Medical Weight Loss and Wellness Program.		
2	Reason for Ordering Program/ Diagnosis	<input checked="" type="checkbox"/> Obesity (278.00): Patient's Height: _____ Weight: _____ BMI: _____ <input checked="" type="checkbox"/> Co morbidities (Check All that apply): <input type="checkbox"/> None <input type="checkbox"/> Sleep Apnea (327.23) <input type="checkbox"/> Diabetes (250.00) <input type="checkbox"/> Osteoarthritis (715.98) <input type="checkbox"/> Hypertension (401.9) <input type="checkbox"/> GERD (530.81) <input type="checkbox"/> Hyperlipidemia (272.4) <input type="checkbox"/> Hypothyroidism (244.9) <input type="checkbox"/> Cardio Vascular Disease, Specify: <input type="checkbox"/> Other:
3	Training Ordered	The following specific training is ordered: <input checked="" type="checkbox"/> Medically Managed Weight Loss Program (16 week course)
4	Clearance for Physical Activity	<input type="checkbox"/> I am not aware of any contraindications toward participation in a fitness program. <input type="checkbox"/> I recommend the applicant not participate in the fitness activities in the program for the following reasons: <input type="checkbox"/> If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers heart rate response). Type of Medication: _____ Effect: _____ Recommendations or restrictions: _____
5	Signature MUST BE HAND SIGNED- STAMPED SIGNATURE NOT ACCEPTABLE	Practitioner's Signature: _____ Date: _____ Practitioner's Name (Printed): _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____