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[Contact@MacrosInc.net](mailto:Contact@MacrosInc.net)

Date:

To whom it may concern:

Ms/Mr. \_\_\_\_\_ has been a patient of mine for \_\_\_\_\_ years. The patient would benefit from, and requires, additional weight loss counseling/coaching to improve their medical prognosis and is a necessity for chronic weight management. The level of intervention required is best undertaken under the guise of professionals who specialize in this area.

In my professional opinion weight loss counseling/coaching is medically necessary and is an appropriate intervention choice for my patients at this time. I am respectfully requesting approval for loss counseling/coaching for my patient.

Sincerely,

Physician Name \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_