Dear Primary Care Provider,

As per insurance requirements for our mutual patient, **3 or 6 months of Medically Managed Weight Loss** have to be conducted through your office for approval for Bariatric Surgery. In an effort to make this difficult and confusing process easier, we have attached instructions and a Monthly Managed Weight Loss form to this letter. *This patient needs to be seen in your office every 29-30 days for either 3 or 6 consecutive months.* If the patient deviates from this schedule, insurance will not approve them for Bariatric Surgery.

Thank you in advance for working with these strenuous requirements concerning our patient and if you have any questions, please do not hesitate to contact our office at 803-376-5982.

Best,
Weight Management Center
1850 Laurel Street Suite 1A
Columbia, SC 29201
Monthly Managed Weight Loss Attempts

Month: 1 / 2 / 3 / 4 / 5 / 6 (circle one)

Date:_____/_____/_____

Patient’s Name:___________________________________

DOB:_____/_____/_____

HT:____”_____’ WT:_____lbs. BMI:_____ 

B/P:_____/______ Pulse:____________

Diagnosis: Morbid Obesity

Diet Plan:

_____ 1200 Cal Daily  _____ 1500 Cal Daily  _____ 1800 Cal Daily

_____Weight Watchers  _____Atkins  _____Decrease Carbs

_____Food Journal  _____________________________Other Diet Plan

Exercise Plan:  _____Walking  _____Treadmill  _____Swimming

_____Aerobics  _____Jogging  _____Spin/Bike

Minutes:_________ Times Per Week:_______

Comments:______________________________

Response to Prescribed Regimen:   Lbs Lost:_______

Comments:__________________________________________________________________________

Goal For Next Visit:   Lose 5-10 lbs for the next 29-30 days
Continue Diet Plan:

_____ 1200 Cal Daily  
_____ 1500 Cal Daily  
_____ 1800 Cal Daily

____ Weight Watchers  
____ Atkins  
____ Decrease Carbs

____ Food Journal  
________________________Other Diet Plan

Exercise Plan:

____ Walking  
____ Treadmill  
____ Swimming

____ Aerobics  
____ Jogging  
____ Spin/Bike

Minutes:_______  
Times Per Week: ______

Comments:_______________________________________________
______________________________________________________________________

Provider Signature:__________________________  
Date:_____/_____/_______