



Certificate of Medical Necessity
Participation in Holistic approach to Obesity Prevention and Education
Weight Management Program

Office number: 804 592.4751 ** FAX: 804 592.4752

Dear Provider,

The individual (child) listed MUST present this Certificate of Medical Necessity, completed in full, to HOPE, prior to participation in the program. It is with your certification, that we will accept this child's entry into the program as they are both medically and psychologically capable in adjusting to a change in healthy lifestyle, Behavioral Health, Nutrition and physical activity program.

Child's Name, Address, City, State, Zip Code, Phone Number, Date of Birth, Age, Male, Female, Parents Name, Race, Date of last Exam, Email, Weight, Height (In Inches), BMI, Percentile, Labs Performed? If yes, provide copy. Yes No

Medical Information

Child's Doctor's Name, Address, City, State, Zip Code, Phone Number, Fax Number

Please provide current diagnosis, including mental health (all that apply)

ICD-10, Description (repeated four times)

Is the child being treated for any co-morbidities? Yes No If yes, please list
Is the child on any medications? Yes No If yes, please list
Does the child have any specific dietary requirements? Yes No If yes, please list
Please provide any additional information that you feel appropriate

Services Requested: HOPE pediatric obesity Program: Behavior Health, Nutrition(RD/CNC), Weight Management Training,

Insurance Information (Please provide a copy of the insurance card)

Insurance Company, Policy Holder Name, Policy#/ID#, Group, Policy Holder DOB, Policy Holder SSN

I confirm, after careful medical examination, that there are no medical/psychological conditions that will hinder or generate a health risk for this child during their participation in Holistic approach to Obesity Prevention and Education, LLC program.

Signed By Date

Printed Name:

NPI#

Please fax to 804-592-4752