acceptable.

Revised 5.4.20

Name: Castillo, Kristi DOB: 11/05/1980 Date:

Letter of Medical Necessity

Section I

Date: 1/3/2023 Employer Name: _____

Patient Name: Kristi Castillo Employee Name: _____

Section II (required for expenses specifically requiring an LMN e.g. weight loss programs, vitamins/supplements, etc.)

Diagnosis: Obesity, Osteoarthritis

Treatment Duration Start date: 12/5/23 End date: unknown

Procedure (CPT) Code: E66.9, M19.90

Hello Navia Benefits:

(Please describe the **medical condition**, the **treatment you recommend**, and **how such treatment relates** to the diagnosed condition)

Patient has obesity. Treatment for this medical condition is Phentermine and Saxenda which are both FDA indicated for Obesity.

Provider's signature: _____

Clinic/Hospital/Office Name: Transform Weight Loss

Address: 19230 Alderwood Mall Parkway suite 120 Lynnwood, WA 98036

Phone Number: 425-305-5182

Note: Navia Benefits requires that proper documentation support your FSA claims. If your letter is incomplete your claim will be denied.

Please Fax to: 1-866-535-9227 or email to: customerservice@naviabenefits.com
Questions? Please call: 1-800-669-3539

Revised 5.4.20

Name: Castillo, Kristi DOB: 11/05/1980 Date: