**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diagnoses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

RE: Coverage for Health and Wellness Coaching

Dear HSA/FSA Plan:

I am writing on behalf of my patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to document the medical necessity to treat their chronic health condition(s) with health coaching and/or personal training at **Fuel for Your Health** in Corunna Michigan. This letter serves to document my patient’s medical history and diagnosis that could benefit from health coaching and/or personal training.

Health coaching and/or personal training are medically necessary and reasonable as part of the treatment for these chronic health conditions to take comprehensive approach to their care and provide additional support to the patient. I ask you to please consider coverage of these services which include: health education, nutrition coaching, movement/exercise coaching, overall mental and physical wellness coaching. Please refer to the enclosed supporting documents (if applicable) for further details, and do not hesitate to call me if you have any questions or if you require additional information.

Health coaching services being requested through:

**Fuel for Your Health (**EIN:33-2616497)

Cindy Reichert-Brooks, RN, MSN, FNP-BC

Jamie Hathcox, AAS, CMA, CPT

211 N. Shiawassee Street, Suite C

Corunna, MI 48817

989-720-0211

mifuelwellness@gmail.com

fuelforyourhealth.net

Thank you for your attention to this matter.

Sincerely,

Provider Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Physician Name and Credentials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_