AdventHealth Weight Loss and Bariatric Surgery
2415 N Orange Ave, Suite 501 Orlando, FL 32804
407-821-3520 | 407-821-3541 FAX
AdventHealthWeightLoss.com

AdventHealth

Letter of Support

The following page is a cover sheet for YOU to fax your Letter of Support template (request) to YOUR Primary Care Physician. You need to fill out the cover sheet:

To: PCP Name

Fax Number: PCP Fax Number

Phone: PCP Phone number

On the next page, complete the bottom portion of the Letter of Support Template with YOUR:

Name

Date of Birth

Phone number

Once complete, fax the two pages (cover sheet and template) to your PCP.

The cover sheet explains what you are asking for and why. Your PCP may require an appointment with you before writing the Letter of Support. It is YOUR responsibility to follow through with them regarding the letter. This Letter of Support is one of your insurance carrier requirements and must be received by us before you can schedule your final appointment to get a surgery date. NO EXCEPTIONS.

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FAX COVER SHEET

To: From:

Fax:

Phone:

Re: **LETTER OF SUPPORT REQUEST**

☐ Urgent ☐ For Review ☐ Please Comment ☒ Please Reply

Comments:

Your patient has chosen our weight loss program to start living a healthier lifestyle. One of their insurance carrier requirements is that they provide us with a LETTER OF SUPPORT from their primary care physician. Please review the following criteria that needs to be included in the letter. If you have any questions regarding this letter, please feel free to call our office or the patient.

Thank you.

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Letter of Support Template for PCP

The patient Letter of Support **MUST** include the following information:

- Letter **TYPED** on your office letterhead and signed
- Patients **FULL** name and date of birth
- How long they have been in your care
- Types of weight loss attempts they have tried (i.e. Jenny Craig, Weight Watchers, medication, etc.)
- Any medical conditions that would benefit from weight loss surgery (i.e. diabetes, sleep apnea, HBP, etc.)
- Most current height and weight **AND** calculated BMI
- Whether or not you, as their provider, support this decision for bariatric surgery
- Additional information needed per insurance company:

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Patient Information:

Patient Name: _________________________

Patient Date of Birth: ___________________

Patient Phone Number: __________________

Please fax TYPED and SIGNED letter to:

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