

Letter of Medical Necessity

For: Simple Life App

Patient Name: _____

Patient ID / Passport number: _____

Date of Birth: _____

Address: _____

Provider Name: _____

Provider Title/Credentials: _____

Provider License number: _____

Provider State of registration: _____

Practice Name: _____

Address: _____

Phone: _____

Date: _____

Diagnosis and Medical Necessity

I am currently treating the above-named patient for one or more of the following diagnosed medical conditions:

- Obesity / Overweight (ICD-10: E66. / E66.3)
- Type 2 Diabetes / Prediabetes (ICD-10: E11. / R73.03)
- Hyperlipidemia (ICD-10: E78.__)
- Hypertension (ICD-10: I10)
- Metabolic Syndrome (ICD-10: E88.81)

- Osteoarthritis (ICD-10: M19.90)
- Other (please specify): _____

Participation in a structured weight management and lifestyle modification program is a necessary component of the patient's treatment plan.

Treatment Recommendation

I am recommending the [Simple Life App](#) as part of the patient's medically supervised care plan to support:

- Nutrition education and improved dietary habits
- Weight management and sustainable fat loss
- Increased physical activity
- Behavioral coaching for lifestyle change
- Reduction in risk factors associated with chronic diseases

The **Simple Life App** delivers evidence-based, personalized guidance through an AI health coach that supports long-term adherence to healthy lifestyle behaviours resulting in weight loss and improved medical status, both regarding the management and prevention of several chronic obesity-related conditions.

Please further describe how the **Simple Life App** program will alleviate or reduce symptoms of the patient's medical condition(s) listed above:

Duration of Use

- 12 months
- Other (please specify): _____

I certify that access to the **Simple Life App** is medically necessary for this patient's ongoing management of the condition(s) listed above.

Provider Signature: _____

Date: _____