Health Insurance Reimbursement
Flexible Spending Accounts (FSA)
Health Reimbursement Accounts (HRA)
Health Savings Accounts (HSA)

Health Insurance Reimbursement

Some health insurance companies consider the cost of the Nutrisystem program to be a reimbursable expense provided certain conditions are met. You may be eligible to receive a full or partial reimbursement for the cost of your Nutrisystem program from your health insurance provider. To determine eligibility we recommend you follow these steps:

1. Ask your doctor to complete the letter of medical necessity attached. Please complete only one of the letters: the Nutrisystem D Letter (diabetic program only) or the Nutrisystem Program Letter (any non-diabetic program).
2. Attach a copy of each Nutrisystem packing slip. The packing slip comes in your Nutrisystem food box and shows both the program type (ex: Nutrisystem Women's Plan) and the price.
3. Submit the signed letter of medical necessity along with your packing slip(s) to your health insurance provider for reimbursement.

Flexible Spending Account (FSA) & Health Reimbursement Account (HRA)

The cost of a weight loss program, when prescribed your physician to treat a diagnosed medical condition such as obesity, hypertension or diabetes, is a reimbursable FSA or HRA expense according to the IRS. Many plan administrators consider the Nutrisystem weight loss program to be a qualified expense under these guidelines. By following the claim process below, you can submit the cost of your Nutrisystem program to your plan administrator for reimbursement.

Claim Process for FSA / HRA

1. Ask your doctor to complete the letter of medical necessity attached. Please complete only one of the letters: the Nutrisystem D Letter (diabetic program only) or the Nutrisystem Program Letter (any non-diabetic program).
2. Fill out a FSA / HRA claim form provided by your plan administrator or HR department.
3. Attach a copy of each Nutrisystem packing slip. The packing slip comes in your Nutrisystem food box and shows both the program type (ex: Nutrisystem Women's Plan) and the price.
4. Submit the signed letter of medical necessity along with the claim form and packing slip(s) to your FSA / HAS administrator for reimbursement. Eligibility for reimbursement of the cost of the Nutrisystem program is at the sole discretion of your plan administrator.

Please note: Nutrisystem does not accept FSA debit cards at this time. Please follow the claim process outlined above to submit your Nutrisystem program expense for reimbursement.

Health Savings Accounts (HSA)

A Health Savings Account (HSA) is a tax-advantaged savings account used solely by individuals enrolled in a High Deductable Health Plan (HDHP) to pay for qualified medical expenses. Expenses paid for weight loss programs, when prescribed by your physician to treat a diagnosed medical condition, are reimbursable. A signed letter of medical necessity (attached) and each of your Nutrisystem program packing slips (found in the box) are required for your records. Please complete only one of the letters: the Nutrisystem D Letter (diabetic program only) or the Nutrisystem Program Letter (any non-diabetic program).

LETTER OF MEDICAL NECESSITY
WEIGHT LOSS: NUTRISYSTEM® D™ PROGRAM[1]

This letter serves as a prescription and letter of medical necessity for the patient referenced below currently being treated for type 2 diabetes or pre-diabetes, and being overweight or obese.

To be filled out by patient:

Patient Name_____ Sex _____DOB_____

Address_____Phone_____

City/State/Zip _____SS#_____

Physician_____Phone_____Fax_____

To be filled out by physician regarding patient listed above:

DATE	HEIGHT	WEIGHT	BMI	BMI Weight Class[2] (check one)
				Normal (18.5 – 24.9) Overweight/ Pre-obese (25.0 – 29.9) Obese (30.0 – 39.9) Extremely Obese (40.0+)

Physician Order: I refer this patient to be on the Nutrisystem D weight loss program.

Diagnoses[3] [4] (check **all** that apply)

___Congestive Heart Failure	___ Obesity	___Hypercholesterolemia
___Morbid Obesity	___ Sleep Apnea	___Coronary Atherosclerosis
___Type 2 Diabetes	___ Hypertriglyceridemia	___Impaired Glucose Tolerance
___Mixed Hyperlipidemia	___ Hypertension	___ Other (list):

Physician
Comments_____

Physician Signature _____ Date _____

THANK YOU!

Patient should keep this letter for tax purposes for proof necessary for reimbursement under a Flexible Spending Account, Health Reimbursement Account, or Health Insurance Coverage Plan.

[1] Foster GD, et al. The effects of a commercially available weight loss program among obese patients with type 2 diabetes: a randomized study. Postgrad Med. 2009 Sep;121(5):113-8.
[2] The International Classification of adult underweight, overweight and obesity according to BMI. WHO 2004.
[3] NIH. Clinical Guildelines on the identification, evaluation, and tratement of overweight and obesity in adults – the evidence report. Obes Res. *1998;651S-209S.*
[4] Centers for Disease Control and Prevention. International Classification of Diseases, Ninth Revision (ICD-9).

LETTER OF MEDICAL NECESSITY
WEIGHT LOSS: NUTRISYSTEM® PROGRAM

This letter serves as a prescription and letter of medical necessity for the patient referenced below currently being treated for obesity or overweight with one or more health consequences and related co-morbidities.

To be filled out by patient:

Patient Name_____ Sex _____DOB_____

Address_____Phone_____

City/State/Zip _____SS#_____

Physician_____Phone_____Fax_____

To be filled out by physician regarding patient listed above:

DATE	HEIGHT	WEIGHT	BMI	BMI Weight Class[1] (check one)
				Normal (18.5 – 24.9) Overweight/ Pre-obese (25.0 – 29.9) Obese (30.0 – 39.9) Extremely Obese (40.0+)

Physician Order: I refer this patient to be on the Nutrisystem weight loss program.

Diagnoses [2][3] (check **all** that apply)

___Congestive Heart Failure	___ Obesity	___Hypercholesterolemia
___Morbid Obesity	___ Sleep Apnea	___Coronary Atherosclerosis
___Type 2 Diabetes	___ Hypertriglyceridemia	___Impaired Glucose Tolerance
___Mixed Hyperlipidemia	___ Hypertension	___ Other (list):

Physician
Comments_____

Physician Signature _____ Date _____

THANK YOU!

Patient should keep this letter for tax purposes for proof necessary for reimbursement under a Flexible Spending Account, Health Reimbursement Account, or Health Insurance Coverage Plan.

[1] The International Classification of adult underweight, overweight and obesity according to BMI. WHO 2004.
[2] Centers for Disease Control and Prevention. International Classification of Diseases, Ninth Revision (ICD-9).
[3] NIH. Clinical Guildelines on the identification, evaluation, and tratement of overweight and obesity in adults – the evidence report. Obes Res. *1998;651S-209S.*