HOPE FITNESS – MEDICAL NECESSITY FORM

Business Name: Hope Fitness
Address: 109 Gainsborough Sq Suite A, Chesapeake, VA 23320
Phone: 757-737-5334

PURPOSE
This form is to verify that participation in structured exercise, personal training and/or group fitness services at Hope Fitness is medically necessary for the below named patient. This documentation allows the patient to utilize eligible FSA/HSA funds toward approved services.

PATIENT INFORMATION
Patient Name: _____
Date of Birth: _____
Phone: _____

CLINICAL NEED
Check all that apply:
■ Weight Management / Obesity Support
■ Hypertension / Blood Pressure Management
■ Metabolic Syndrome / Insulin Resistance / Pre-Diabetes
■ Women's Health / Postpartum Core + Pelvic Floor Support
■ Preventative Wellness to prevent future medical risk
■ Other: _____

RECOMMENDATION + APPROVAL
I am recommending the patient participate in medically necessary exercise under the supervision of certified fitness professionals at Hope Fitness.
Select all that apply:
■ Personal Training Sessions
■ Group Fitness Classes

Recommended frequency: _____ sessions per week for _____ months.

PROVIDER INFORMATION
Provider Name: _____
Provider Title (MD, DO, NP, PA, PT, etc.): _____
Provider Phone: _____
Provider Address: _____

Signature: _____ Date: _____

NOTE FOR PATIENT / MEMBER
Keep a copy of this signed form for your records. Hope Fitness will maintain one on file to support

HSA/FSA eligibility documentation.