



**Trinity Bariatric & Weight Loss Center**  
1500 Johns Road Suite 3  
Augusta, Ga. 30904  
Telephone: (706)-481-7298 Fax: (706)-481-7971

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Dear Patient,

Enclosed is the supervised diet template that you will need to take to your doctor as per the requirement of your insurance company. Please note that adequate notes will need to be documented and you must be seen by the physician each month and weighed each month. **If there are any significant gaps in the supervised diet period insurance will deny coverage.** There must be notations of any exercise and changes in your lifestyle at each visit. The physician can use their charting system in order to put in notes, but all of the information on the sheets must be addressed in order to meet what the insurance will be requiring.

In addition, your insurance company will either require a 2 or 5 year weight history. This means that a chart from 2 to 5 years for each year must be submitted with the 6 month diet. **The insurance company will not take a simple letter from your doctor with an overview of the diet; it must be chart notes only.** It will be also helpful to have a letter from your physician on what health related problems you are having from your weight.

If you or your physician has any questions please contact our office and speak directly with our insurance consultants.

Sincerely,  
Trinity Hospital of Augusta – Bariatric Program  
706-481-7298



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Dear Colleague,

Patient: \_\_\_\_\_, DOB: \_\_\_\_\_ is being seen for consideration of \_\_\_\_\_Laparoscopic Roux-en-Y Gastric Bypass \_\_\_\_\_Laparoscopic Gastric Banding. From our assessment and in compliance with the National Institute of Health (NIH) criteria this patient meets all basic criteria for consideration, however, at this time the patient's insurance is requiring your patient to undergo \_\_\_\_\_ consecutive months of physician supervised and documented weight loss prior to being eligible for surgical services. While we understand that most patients have a long history of unsuccessful weight loss management for numerous reasons, we must comply with their guidelines.

Enclosed you will find an assessment form that may be completed on each medical visit, you are welcome to use your own form. We hope this form will make assessing your patient easier as well as provide consistency in fulfilling the insurance requirements to expedite your patient's surgical needs.

Simply complete the enclosed form and fax back to us at 706-481-7971 each month the patient visits your practice.

If you have any questions or comments, please do not hesitate to contact us.

Sincerely,

Trinity Bariatric and Weight Loss Center Staff

# Physician Supervised Weight Loss Visit Month 1

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Physician: \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ TEMP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Diagnosis: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Current Dietary  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Activity/Exercise  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Behavioral  
Interventions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consideration of or use of Pharmacotherapy w/FDA approved medication if  
appropriate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Addition Comments and/or  
recomendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_ Signature \_\_\_\_\_

## Physician Supervised Weight Loss Visit Month 2

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Physician: \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ TEMP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Diagnosis: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Current Dietary  
Program: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physical Activity/Exercise  
Program: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Behavioral  
Interventions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Consideration of or use of Pharmacotherapy w/FDA approved medication if  
appropriate: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Addition Comments and/or  
recomendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_ Signature \_\_\_\_\_

# Physician Supervised Weight Loss Visit Month 3

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Physician: \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ TEMP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Diagnosis: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Current Dietary  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Activity/Exercise  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Behavioral  
Interventions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consideration of or use of Pharmacotherapy w/FDA approved medication if  
appropriate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Addition Comments and/or  
recomendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_ Signature \_\_\_\_\_

# Physician Supervised Weight Loss Visit Month 4

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Physician: \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ TEMP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Diagnosis: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Current Dietary  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Activity/Exercise  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Behavioral  
Interventions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consideration of or use of Pharmacotherapy w/FDA approved medication if  
appropriate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Addition Comments and/or  
recomendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_ Signature \_\_\_\_\_

# Physician Supervised Weight Loss Visit Month 5

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Physician: \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ TEMP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Diagnosis: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Current Dietary  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Activity/Exercise  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Behavioral  
Interventions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consideration of or use of Pharmacotherapy w/FDA approved medication if  
appropriate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Addition Comments and/or  
recomendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_ Signature \_\_\_\_\_

# Physician Supervised Weight Loss Visit Month 6

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Physician: \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ TEMP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Diagnosis: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Current Dietary  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Activity/Exercise  
Program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Behavioral  
Interventions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consideration of or use of Pharmacotherapy w/FDA approved medication if  
appropriate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Addition Comments and/or  
recomendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_ Signature \_\_\_\_\_