Date: [Date]

To: [Surgeon Name/Bariatric Program Name]
Fax/Address: [Recipient Address or Fax Number]

RE: Letter of Medical Necessity for Bariatric Surgery Evaluation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance ID: [Insurance ID Number]

Dear [Surgeon Name or Bariatric Committee],

I am writing to formally refer [Patient Name] for a bariatric surgery candidacy evaluation. This patient has a current BMI of [BMI Number] and a weight of [Weight] lbs.

The patient has been diagnosed with the following obesity-related comorbidities:

- [e.g., Type 2 Diabetes]
- [e.g., Obstructive Sleep Apnea]
- [e.g., Hypertension]
- [e.g., Hyperlipidemia]

Despite previous attempts at supervised weight loss through [e.g., nutrition counseling, exercise programs, or pharmacotherapy], the patient has been unable to achieve or maintain a healthy weight. I believe that bariatric surgery is medically necessary to mitigate the risks associated with their morbid obesity and to improve their long-term health outcomes.

The patient is psychologically stable and demonstrates a clear understanding of the lifestyle changes required for success post-surgery. I fully support their pursuit of surgical intervention.

Please find the patient's recent clinical notes and lab results attached. If you require further documentation for insurance authorization, please contact my office.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[Phone Number]
[NPI Number]