[Date]

[Insurance Company Name]
[Attn: Prior Authorization Department]
[Insurance Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Bariatric Surgery

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request prior authorization for [Procedure Name, e.g., Roux-en-Y Gastric Bypass or Sleeve Gastrectomy, CPT Code: XXXX] for my patient, [Patient Name].

Clinical Documentation:

- **Current BMI:** [Current BMI] kg/m²
- **Height:** [Height in inches/cm]
- **Weight:** [Weight in lbs/kg]

Co-morbid Conditions:
The patient suffers from the following obesity-related conditions:

- [Condition 1, e.g., Type 2 Diabetes (ICD-10 Code)]
- [Condition 2, e.g., Obstructive Sleep Apnea (ICD-10 Code)]
- [Condition 3, e.g., Hypertension (ICD-10 Code)]

Weight Loss History:
[Patient Name] has attempted multiple physician-supervised weight loss programs, including [List Programs/Dates]. Despite these efforts and pharmacological interventions, the patient has been unable to maintain significant weight loss.

Medical Clearance:
The patient has undergone a comprehensive evaluation and has been cleared by:

- A registered dietitian for nutritional counseling.
- A licensed mental health professional for psychological clearance.
- A primary care physician for surgical readiness.

In my professional medical opinion, bariatric surgery is medically necessary for this patient to reduce the risks associated with morbid obesity and to improve long-term health outcomes. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

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