

[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To: [Insurance Company Name]
Attn: Bariatric Surgery Authorization Department
Fax: [Fax Number]

RE: Letter of Medical Necessity and Documentation of Supervised Weight Loss

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

To Whom It May Concern,

This letter serves to document that [Patient Name] has undergone a medically supervised weight loss program under my direct supervision for a period of [Number] consecutive months, beginning on [Start Date] and ending on [End Date].

During this period, the patient was seen monthly for nutritional counseling, behavioral modification, and exercise guidance. The following is a summary of the supervised visits:

- **Month 1:** [Date] - Weight: [Weight] - Plan: [e.g., Low calorie diet, 30 min walking]
- **Month 2:** [Date] - Weight: [Weight] - Plan: [e.g., Increased protein intake, portion control]
- **Month 3:** [Date] - Weight: [Weight] - Plan: [e.g., Calorie tracking, aerobic exercise]
- **Month 4:** [Date] - Weight: [Weight] - Plan: [e.g., Reduction of processed sugars]
- **Month 5:** [Date] - Weight: [Weight] - Plan: [e.g., Consistent meal timing]
- **Month 6:** [Date] - Weight: [Weight] - Plan: [e.g., Maintenance of dietary changes]

Despite the patient's active participation and adherence to the supervised program, they have been unable to achieve or maintain significant long-term weight loss to resolve their morbid obesity and associated co-morbidities, which include [List Co-morbidities, e.g., Type 2 Diabetes, Hypertension, Sleep Apnea].

Based on the patient's history and the failure of conservative weight loss measures, I highly recommend that [Patient Name] proceed with [Type of Bariatric Surgery]. This procedure is medically necessary to reduce the risk of life-threatening complications associated with their obesity.

Please contact my office at [Phone Number] if you require additional clinical notes or documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]