[Physician 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 Full Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request authorization for [Procedure Type, e.g., Gastric Sleeve/Gastric Bypass] for my patient, [Patient Name]. The patient currently has a BMI of [BMI Number] and meets the clinical criteria for surgical intervention due to the following life-threatening comorbidities:

- **[Comorbidity 1, e.g., Type 2 Diabetes]:** Diagnosed on [Date]. Currently managed with [Medications]. Despite treatment, [HbA1c levels/symptoms] remain sub-optimal.
- **[Comorbidity 2, e.g., Obstructive Sleep Apnea]:** Confirmed via sleep study on [Date]. Patient requires CPAP usage; weight loss is medically necessary to reduce airway obstruction.
- **[Comorbidity 3, e.g., Hypertension]:** Persistent high blood pressure requiring [Number] daily medications.
- **[Comorbidity 4, e.g., Non-Alcoholic Fatty Liver Disease]:** Evidence of [Elevated enzymes/imaging results].

The patient has attempted supervised weight loss programs including [List attempts: e.g., Weight Watchers, nutritional counseling, exercise programs] for a period of [Number] months without sustained success.

In my professional medical opinion, the patient is at high risk for significant morbidity and mortality without surgical intervention. Bariatric surgery is the most effective treatment to achieve long-term resolution of these comorbidities and reduce future healthcare costs associated with chronic disease management.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[Medical Practice Name]
[NPI Number]