

[Physician Name, MD/DO]  
[Clinic Name]  
[Clinic Address]  
[City, State, Zip Code]  
[Phone Number]  
[Fax Number]

Date: [Date]

To: [Insurance Company Name / Bariatric Surgery Center]  
Re: [Patient Full Name]  
Date of Birth: [Patient DOB]  
Member ID: [Insurance ID Number]

To Whom It May Concern,

I am writing to provide formal medical clearance and support for [Patient Name] to undergo bariatric surgery. The patient has been under my care for the management of endocrine-related conditions, including [List diagnoses, e.g., Type 2 Diabetes, Hypothyroidism, PCOS, Obesity].

Current Clinical Findings:

- BMI: [Current BMI]
- Relevant Labs: [e.g., HbA1c levels, Thyroid panel results]
- Comorbidities: [e.g., Hypertension, Sleep Apnea, Metabolic Syndrome]

The patient has attempted supervised weight loss through [List methods: e.g., pharmacological therapy, nutritional counseling, lifestyle modification] without achieving long-term success. It is my clinical opinion that the patient is an excellent candidate for this procedure. Bariatric surgery is medically necessary to improve [Patient Name]'s glycemic control and reduce the risk of further metabolic complications.

From an endocrinology standpoint, the patient is medically stable for anesthesia and the surgical intervention. Post-operatively, I will continue to manage the patient's endocrine health and adjust medications as weight loss progresses.

I strongly recommend approval for [Requested Procedure Name]. If you require any additional clinical documentation, please do not hesitate to contact my office.

Sincerely,

[Physician Signature]

[Physician Printed Name]  
Department of Endocrinology