

[Your Name]  
[Your Address]  
[City, State, Zip Code]  
[Phone Number]  
[Email Address]

[Date]

[Appeals Department Name]  
[Insurance Company Name]  
[Insurance Company Address]  
[City, State, Zip Code]

**RE: Letter of Appeal for Denial of Bariatric Surgery**

Patient Name: [Your Full Name]  
Policy Number: [Your Policy Number]  
Group Number: [Your Group Number]  
Claim/Reference Number: [Denial Reference Number]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for bariatric surgery (CPT Code: [Insert Code]), which was requested by my physician, [Physician Name]. The reason for denial stated in your letter dated [Date of Denial Letter] was [State the reason provided in the denial letter].

I believe this procedure is medically necessary for the following reasons:

- **Health Conditions:** I currently suffer from [List co-morbidities such as Type 2 Diabetes, Sleep Apnea, Hypertension, etc.]. These conditions are significantly impacted by my weight and have not responded sufficiently to conventional treatments.
- **Supervised Weight Loss Efforts:** I have participated in multiple supervised weight loss programs, including [List specific programs, dates, and durations]. Despite these efforts, I have been unable to maintain significant weight loss.
- **Physician Recommendation:** My primary care physician and my bariatric surgeon both agree that this surgery is the most effective intervention to prevent further life-threatening complications.

Enclosed, please find supporting documentation including medical records, a letter of medical necessity from my surgeon, and a detailed history of my previous weight loss attempts.

I request that you reconsider your decision and authorize this procedure. I look forward to your response within the time frame required by my policy. Please contact me at [Your Phone Number] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name]