

**Date:** [Date]

**To:** [Insurance Company Name]

**Attention:** Utilization Management/Prior Authorization Department

**Address:** [Insurance Company Address]

**RE:** Letter of Medical Necessity for Bariatric Surgery Revision

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Member ID:** [Insurance Member ID]

**Group Number:** [Group Number]

To Whom It May Concern,

I am writing to formally request authorization for a bariatric surgery revision (CPT Code: [Insert Code]) for my patient, [Patient Name]. This procedure is medically necessary due to [select: surgical complications / inadequate weight loss / weight regain / clinical failure] following the patient's initial bariatric procedure performed on [Date of Original Surgery].

**Clinical History:**

The patient currently presents with a BMI of [Current BMI]. Since their initial [Type of Original Surgery], the patient has experienced the following complications:

- [List complication, e.g., Severe GERD/Acid Reflux]
- [List complication, e.g., Gastric pouch dilation]
- [List complication, e.g., Stomal stenosis or stricture]
- [List complication, e.g., Persistent comorbid conditions like Type 2 Diabetes]

**Attempted Conservative Treatments:**

The patient has attempted to manage these issues through conservative measures, including [list measures, e.g., dietary modifications, pharmacotherapy, and exercise programs] under medical supervision for a period of [Number] months. Despite these efforts, the patient's condition has not improved, and their health remains at risk.

**Proposed Procedure:**

After a thorough evaluation, I am recommending a revision to [Type of New Surgery, e.g., Roux-en-Y Gastric Bypass]. This revision is necessary to correct the mechanical failure of the original surgery and to treat the patient's worsening metabolic health.

**Physician Recommendation:**

It is my professional opinion that this revision is the only viable option to prevent further morbidity and to ensure the long-term health of the patient. I request your immediate approval for this procedure.

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

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical Practice Name]

[NPI Number]