

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

[Date]

[Insurance Company Name]  
[Attn: Appeals/Expedited Review Department]  
[Insurance Address]  
[City, State, Zip Code]

**RE: Expedited Request for Prior Authorization for Bariatric Surgery**

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

To Whom It May Concern,

I am writing to formally request an **expedited** authorization for bariatric surgery ([Specific Procedure Name, e.g., Gastric Sleeve or Gastric Bypass]). My primary surgeon, [Surgeon's Name], has recommended this procedure as a medical necessity to treat life-threatening comorbidities.

This request is urgent due to the following acute medical conditions:

- [Condition 1: e.g., Severe Obstructive Sleep Apnea requiring CPAP]
- [Condition 2: e.g., Uncontrolled Type 2 Diabetes]
- [Condition 3: e.g., Hypertension or Cardiac Stress]

Delayed treatment poses a significant risk to my health and may lead to [mention specific risk, e.g., cardiovascular event or permanent disability]. Standard processing times for this authorization will jeopardize my physical well-being and safety.

Attached you will find a Letter of Medical Necessity from my physician, clinical notes, and recent diagnostic test results supporting the urgency of this intervention.

Please provide a decision within [Number, e.g., 48-72] hours as per the expedited review guidelines. You may contact my surgeon's office at [Surgeon's Phone Number] or me directly at [Your Phone Number] for any additional information.

Thank you for your immediate attention to this life-saving request.

Sincerely,

[Your Signature]

[Your Printed Name]