

**Date:** [Insert Date]

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

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

**Policy Number:** [Insert Insurance ID Number]

**To Whom It May Concern,**

This letter serves as formal documentation regarding the supervised medical weight loss efforts for the above-named patient. The patient has been under my clinical supervision for the treatment of morbid obesity (ICD-10: [Insert Code]) from [Start Date] to [End Date].

**Supervised Programs and Interventions:**

- **Duration:** [Number] months of physician-supervised weight management.
- **Dietary Counseling:** [Details of specific diet, e.g., low-calorie, high-protein].
- **Physical Activity:** [Details of exercise regimen/recommendations].
- **Pharmacotherapy:** [List medications trialed, e.g., Phentermine, GLP-1 agonists, etc.].
- **Behavioral Therapy:** [Details of counseling or lifestyle modifications].

**Clinical Outcomes:**

Despite strict adherence to the prescribed multidisciplinary program, the patient has failed to achieve or maintain clinically significant weight loss. Current BMI: [Insert BMI]. Starting Weight: [Insert Weight]. Current Weight: [Insert Weight].

**Related Comorbidities:**

- [e.g., Hypertension]
- [e.g., Type 2 Diabetes]
- [e.g., Obstructive Sleep Apnea]

**Clinical Recommendation:**

Due to the failure of conservative medical management and the persistent health risks associated with the patient's current weight, I am recommending [Insert Procedure/Advanced Treatment, e.g., Bariatric Surgery].

Please contact my office at [Phone Number] if further documentation is required.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic Name]

[NPI Number]