[Physician Name, MD/DO]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To: [Insurance Company Name]
Attn: Medical Review/Prior Authorization Department
[Insurance Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Bariatric Surgery Evaluation

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request a referral and prior authorization for a bariatric surgery evaluation for my patient, [Patient Name]. I have been treating this patient since [Date] for Morbid Obesity and its associated comorbid conditions.

Clinical Documentation:

- Current Height: [X] inches
- Current Weight: [X] lbs
- Current BMI: [X] kg/m

Co-morbidities:
The patient suffers from the following obesity-related conditions:
[List conditions, e.g., Type 2 Diabetes, Hypertension, Obstructive Sleep Apnea, Hyperlipidemia, Degenerative Joint Disease].

Weight Loss History:
[Patient Name] has made multiple unsuccessful attempts at medically supervised weight loss, including [List methods, e.g., commercial programs, pharmacotherapy, and exercise regimens]. Despite these efforts, the patient has been unable to achieve or maintain a healthy weight.

Medical Necessity:
Based on the patient's BMI and the presence of significant comorbidities, I believe that a multidisciplinary bariatric evaluation is medically necessary. Bariatric surgery is the most effective long-term treatment to reduce the patient's risk of cardiovascular events, improve metabolic health, and increase life expectancy.

I strongly recommend that [Patient Name] be evaluated by a bariatric surgical team to determine candidacy for surgical intervention. Please contact my office at [Phone Number] if you require additional medical records or information.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[NPI Number]