

Date: [Insert Date]

To: [Insurance Company Name]

Attention: Medical Review Department

Fax/Address: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Weight Loss Program

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Policy Number: [Policy ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for a medically supervised weight loss program for my patient, [Patient Name]. This program is a vital component of the treatment plan for the management of the patient's Type 2 Diabetes Mellitus.

Diagnosis and Clinical History:

The patient has been diagnosed with Type 2 Diabetes (ICD-10: E11.9). Current clinical data is as follows:

- Current Height: [Insert Height]
- Current Weight: [Insert Weight]
- BMI: [Insert BMI]
- Recent HbA1c: [Insert Result]%

Medical Necessity:

The patient's current weight is significantly impacting their glycemic control and increasing the risk of secondary complications including cardiovascular disease, neuropathy, and retinopathy. Significant clinical evidence suggests that a structured weight loss program can improve insulin sensitivity and lead to a reduction in HbA1c levels.

Treatment Plan:

I have prescribed the [Name of Weight Loss Program] as a medical intervention. This program provides the necessary nutritional counseling, behavioral modification, and physical activity supervision required to achieve therapeutic weight loss targets that cannot be achieved through unsupervised diet and exercise alone.

In my professional medical opinion, this program is medically necessary to manage [Patient Name]'s Type 2 Diabetes and prevent further health deterioration. Failure to provide this intervention may result in increased medication requirements or emergency complications.

Please contact my office at [Phone Number] if you require any additional documentation or clinical notes.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical License Number]

[Practice Name]