[Date]
[Insurance Company Name]
[Prior Authorization Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Weight Loss Treatment
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID Number: [ID Number]
Group Number: [Group Number]

Dear Medical Review Board,

I am writing on behalf of [Patient Name] to request prior authorization for comprehensive medical weight management services at [Clinic Name].

Patient Clinical History:
The patient is currently diagnosed with [Primary Diagnosis, e.g., Morbid Obesity] (ICD-10 Code: [Code]). As of [Date], the patient's BMI is [Number] kg/m, with a current weight of [Weight].

Associated Comorbidities:
The patient suffers from the following weight-related health conditions:

- [Condition 1, e.g., Type 2 Diabetes] (ICD-10: [Code])
- [Condition 2, e.g., Hypertension] (ICD-10: [Code])
- [Condition 3, e.g., Obstructive Sleep Apnea] (ICD-10: [Code])

Previous Interventions:
[Patient Name] has attempted to lose weight through several supervised and unsupervised methods, including [List previous attempts, e.g., Weight Watchers, diet and exercise programs, or specific medications]. Despite these efforts, the patient has been unable to maintain significant weight loss to improve their clinical health markers.

Treatment Plan:
Treatment at [Clinic Name] will include [List services, e.g., physician-supervised nutrition planning, behavioral counseling, and pharmacotherapy]. This structured intervention is medically necessary to reduce the patient's risk of [List risks, e.g., cardiovascular disease or stroke] and to manage existing comorbidities.

Based on the patient's clinical profile and history, I recommend immediate approval for this treatment. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical License Number]
[Practice Name]