

**[Physician Name/Clinic Name]**

[Physician Address]

[City, State, Zip Code]

[Phone Number]

[Date]

**TO:** [Insurance Company Name]

**ATTN:** Medical Review/Prior Authorization Department

**RE:** Letter of Medical Necessity for Supervised Weight Reduction

**PATIENT:** [Patient Name]

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

**POLICY ID:** [Insurance ID Number]

To Whom It May Concern,

I am writing to formally document the medical necessity for [Patient Name] to undergo a supervised weight reduction program as a clinical prerequisite for [Type of Surgery, e.g., Total Knee Arthroplasty].

**Clinical Diagnosis:**

The patient suffers from [Diagnosis, e.g., Grade IV Osteoarthritis of the Right Hip] and [Obesity/BMI Category]. Due to the severity of their orthopedic condition, surgical intervention is required to restore mobility and reduce chronic pain.

**Medical Necessity for Weight Loss:**

Current clinical guidelines and surgical safety protocols require the patient to achieve a BMI of [Target BMI] or lose [Number] pounds prior to surgery. This weight reduction is medically necessary to:

- Reduce the high risk of perioperative complications, including infection and venous thromboembolism.
- Minimize excessive mechanical stress on the prosthetic implant, ensuring long-term surgical success.
- Improve the patient's ability to participate in essential post-operative physical therapy and rehabilitation.

**Treatment Plan:**

I have prescribed a supervised program consisting of [e.g., nutritional counseling, low-impact exercise, or metabolic monitoring]. This program is an integral component of the patient's pre-surgical orthopedic care plan.

Given the patient's functional limitations and the urgency of the upcoming surgery, I request approval for the weight reduction services required to meet these safety standards.

Sincerely,

[Physician Signature]  
[Physician Name, Title]  
[NPI Number]