[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity and Formal Appeal
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy ID Number: [Policy ID]
Claim/Reference Number: [Reference Number]

Dear Medical Review Board,

I am writing to formally appeal the denial of coverage for [Medication/Procedure Name] for my patient, [Patient Name]. This treatment is medically necessary to treat [Patient Name]'s diagnosis of obesity (ICD-10: [Code]) and associated life-threatening comorbidities.

Clinical History and Diagnosis:
The patient has a Body Mass Index (BMI) of [BMI Number]. [Patient Name] has been under my care for [Duration] and has attempted the following supervised weight loss interventions without success: [List previous diets, exercise programs, or medications].

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

- [Condition 1, e.g., Hypertension]
- [Condition 2, e.g., Type 2 Diabetes]
- [Condition 3, e.g., Obstructive Sleep Apnea]

Medical Justification:
[Medication/Procedure Name] is an essential component of the treatment plan to prevent further disease progression and reduce the risk of cardiovascular events. Clinical data indicates that for a patient with this profile, this treatment is the standard of care to achieve significant metabolic improvement.

I request that you overturn the previous denial and approve coverage for this treatment. Please contact my office at [Phone Number] if you require additional medical records or documentation.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number/NPI]