[Physician Date]

[Physician Name, MD/DO]
[Facility Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]

RE: Letter of Medical Necessity for Dietary Modifications
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Insurance ID: [ID Number]
Policy/Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally document the medical necessity of specific dietary modifications and nutritional interventions for [Patient Name]. This patient underwent bariatric surgery ([Type of Surgery, e.g., Gastric Bypass/Sleeve Gastrectomy]) on [Date of Surgery].

Due to the anatomical and physiological changes resulting from this procedure, the patient is at significant risk for malabsorption, dumping syndrome, and micronutrient deficiencies. To ensure postoperative safety and long-term health, the following dietary requirements are medically necessary:

- High-protein intake (minimum [X] grams per day) to prevent muscle wasting and support healing.
- Medical-grade protein supplements (shakes/powders) to meet metabolic demands.
- Specific vitamin and mineral supplementation (B12, Iron, Calcium Citrate, Fat-soluble vitamins) to prevent deficiency-related diseases.
- Strict limitation of simple sugars and high-fat foods to prevent Dumping Syndrome and reactive hypoglycemia.
- [Optional: Additional specific restriction or requirement].

These modifications are not for general wellness, but are essential components of the clinical treatment plan for the diagnosis of [ICD-10 Code, e.g., E66.01 Morbid Obesity and Z98.84 Bariatric Surgery Status]. Failure to adhere to these modifications may result in severe metabolic complications, hospitalization, or surgical failure.

Should you require further documentation or clinical notes, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]