

Date: [Date]

To: [Insurance Company Name]

Department: Prior Authorization Department

Fax/Address: [Fax Number or Mailing Address]

RE: Initial Prior Authorization Request for Elective Bariatric Surgery

Patient Name: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Member ID: [Insurance ID Number]

Group Number: [Group Number]

Dear Prior Authorization Department,

I am writing to request prior authorization for a **Roux-en-Y Gastric Bypass (CPT Code: 43644)** for the above-referenced patient. This elective procedure is scheduled for [Proposed Date] at [Facility Name].

Clinical Documentation:

- **Diagnosis:** Morbid Obesity (ICD-10 Code: [e.g., E66.01])
- **Current BMI:** [Patient's BMI]
- **Co-morbidities:** [List conditions, e.g., Type 2 Diabetes, Hypertension, Sleep Apnea]

Medical Necessity Summary:

The patient has a long-standing history of morbid obesity and has been unable to achieve sustained weight loss through non-surgical means. Attached you will find the following supporting documentation:

- Detailed medical history and physical examination.
- Records of supervised weight loss attempts (Duration: [Number] months).
- Psychological clearance evaluation.
- Nutritional counseling clearance from a registered dietitian.
- Results of recent laboratory work and diagnostic testing.

Based on the patient's clinical profile and documented failure of conservative treatments, this procedure is medically necessary to prevent further life-threatening complications. Please review this request and provide a determination at your earliest convenience.

Should you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]
[Practice Address]