[Physician Date]

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

RE: Initial Prior Authorization Request for Heavy Duty Bariatric Walker
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case Reference Number: [If applicable]

To Whom It May Concern,

I am writing to formally request prior authorization for a Heavy Duty Bariatric Walker (HCPCS Code: E0148/E0149) for the above-referenced patient. This durable medical equipment is medically necessary to manage the patient's mobility limitations and ensure safety within the home environment.

Clinical Documentation:

- **Primary Diagnosis:** [Primary Diagnosis, e.g., Morbid Obesity, Osteoarthritis] (ICD-10: [Code])
- **Secondary Diagnosis:** [Secondary Diagnosis, e.g., Gait Abnormality] (ICD-10: [Code])
- **Patient Current Weight:** [Weight] lbs
- **Weight Capacity Requirement:** The patient requires a reinforced frame as their weight exceeds the 300 lb limit of a standard walker.

Medical Necessity:
The patient suffers from significant mobility deficits that prevent them from performing Activities of Daily Living (ADLs) safely. A standard walker is clinically inappropriate and poses a safety risk due to weight capacity limitations. The requested bariatric walker provides the necessary structural integrity and wider base required for the patient's body habitus and stability.

Functional Limitations:
[Describe specific limitations, e.g., inability to ambulate more than 10 feet without rest, history of falls, or severe joint pain during weight-bearing].

Please find the enclosed clinical notes and signed prescription. Should you require further information, please contact my office at [Phone Number]. Thank you for your prompt attention to this request.

Sincerely,

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