[Physician Name, MD/DO]
[Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Letter of Medical Necessity for Bariatric Surgery Evaluation

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request a referral and prior authorization for a bariatric surgery evaluation for my patient, [Patient Name].

[Patient Name] has a current BMI of [Current BMI] kg/m, with a height of [Height] and a weight of [Weight]. The patient has been diagnosed with morbid obesity (ICD-10 E66.01) and suffers from the following obesity-related comorbidities:

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

The patient has made multiple supervised attempts to achieve significant and sustained weight loss through conventional methods, including [list methods, e.g., calorie-restricted diets, exercise programs, and pharmacotherapy]. Despite these efforts, the patient has been unable to maintain a healthy weight, and their comorbid conditions remain a significant risk to their long-term health.

In my clinical opinion, a multidisciplinary bariatric evaluation is medically necessary to determine if the patient is a candidate for surgical intervention. Bariatric surgery is the most effective treatment for achieving significant weight loss and resolving or improving the aforementioned life-threatening comorbidities for this patient.

I request your approval for the initial consultation and necessary pre-operative screenings. Should you require additional medical records or documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[NPI Number]