

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]
[Date]

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

RE: Appeal of Denial for Bariatric Surgery Evaluation

Patient Name: [Your Name]
Member ID Number: [Your ID Number]
Group Number: [Your Group Number]
Claim/Reference Number: [Denial Reference Number]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for a bariatric surgery evaluation, as stated in your letter dated [Date of Denial Letter]. The reason for denial provided was [State reason given by insurance, e.g., "not a covered benefit" or "medical necessity not met"].

I am requesting a reconsideration based on the following information:

Medical Necessity:

My current Body Mass Index (BMI) is [Your BMI]. I have been diagnosed with the following obesity-related comorbidities: [List conditions, e.g., Type 2 Diabetes, Hypertension, Sleep Apnea]. These conditions significantly impact my health and quality of life.

Previous Weight Loss Efforts:

I have attempted to lose weight through multiple supervised programs, including:

- [Program Name/Method] from [Date] to [Date]
- [Program Name/Method] from [Date] to [Date]

Despite these efforts, I have been unable to achieve or maintain a healthy weight.

Physician Recommendation:

My primary care physician, [Doctor's Name], has recommended this evaluation as a necessary step to determine if surgical intervention is the most effective treatment for my chronic obesity and associated health risks.

Attached please find supporting documentation, including medical records and a letter of medical necessity from my physician. I request that you review this additional information and approve the coverage for my bariatric surgery evaluation.

Thank you for your time and prompt attention to this matter. I look forward to your response within [Number of days, e.g., 30] days.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures:

Copy of Denial Letter

Letter of Medical Necessity from [Doctor's Name]

Relevant Medical Records