

Date: [Date]

To: [Insurance Company Name]

Attn: Utilization Management / Authorization Department

Fax/Address: [Fax Number or Address]

RE: Request for Prior Authorization for Pre-Surgical Bariatric Screening

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [Insurance ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to request prior authorization for a comprehensive pre-surgical bariatric screening for the above-referenced patient. This screening is a clinical requirement to determine the patient's candidacy for metabolic and bariatric surgery.

Requested Services:

- [CPT Code]: Psychological Evaluation for Bariatric Surgery
- [CPT Code]: Nutritional Assessment/Dietary Consultation
- [CPT Code]: Multidisciplinary Surgical Consultation
- [CPT Code]: Laboratory Workup/Diagnostic Imaging

Clinical Justification:

The patient has a current BMI of [BMI] and a diagnosis of morbid obesity (ICD-10: [Code]). The patient also suffers from the following comorbidities: [List Comorbidities, e.g., Type 2 Diabetes, Hypertension, Sleep Apnea]. Previous supervised weight loss attempts have been unsuccessful. This screening is necessary to ensure the patient meets the medical and psychological criteria for a safe surgical outcome.

Provider Information:

Facility Name: [Clinic/Hospital Name]

Tax ID: [Tax ID]

NPI: [NPI Number]

Contact Person: [Name]

Phone Number: [Phone Number]

Please review this request and provide a determination via fax to [Fax Number]. If additional clinical documentation is required, please contact our office immediately.

Sincerely,

[Physician Name]

[Physician Title]

[Medical Practice Name]