

Date: [Date]

To: [Insurance Company Name]

Attention: Prior Authorization Department

Fax Number: [Fax Number]

Re: Request for Bariatric Evaluation Consultation

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 specialist consultation for my patient, [Patient Name], to undergo a comprehensive bariatric evaluation. I am referring this patient to [Name of Bariatric Surgeon/Center] for a formal assessment regarding surgical intervention for morbid obesity.

Clinical Documentation:

- **Current BMI:** [BMI Value] kg/m²
- **Weight:** [Weight] lbs
- **Height:** [Height]
- **ICD-10 Diagnosis:** [e.g., E66.01 Morbid obesity due to excess calories]

Co-morbid Conditions:

The patient suffers from the following obesity-related conditions: [List conditions, e.g., Type 2 Diabetes, Hypertension, Obstructive Sleep Apnea, Hyperlipidemia].

Reason for Consultation:

The patient has attempted various non-surgical weight loss programs, including [mention diets, medications, or supervised programs] without achieving sustained weight loss. Due to the severity of the patient's obesity and associated health risks, a multidisciplinary evaluation by a bariatric specialist is medically necessary to determine candidacy for metabolic and bariatric surgery.

Requested Services:

CPT Code: [e.g., 99204 or 99205] - Office/Outpatient Consultation

Thank you for your prompt attention to this request. If you require additional clinical notes or history, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]