

[Date]

[Patient Name]

[Patient Date of Birth]

[Patient ID/Insurance Number]

To: [Bariatric Surgery Department/Clinic Name]

From: [Referring Provider Name/Insurance Coordinator]

Subject: Authorization for Multidisciplinary Bariatric Surgery Evaluation

Dear Bariatric Surgery Team,

This letter serves as formal approval and referral for **[Patient Name]** to undergo a comprehensive multidisciplinary bariatric surgery evaluation. This approval includes consultations with the following specialties:

- Bariatric Surgical Consultation
- Nutritional Assessment and Counseling
- Psychological/Psychiatric Evaluation
- Medical/Internal Medicine Clearance

Clinical Documentation:

The patient currently has a BMI of **[Insert BMI]** and has been diagnosed with the following comorbid conditions: **[List conditions, e.g., Type 2 Diabetes, Sleep Apnea, Hypertension]**. The patient has attempted previous supervised weight loss programs without sustained success.

Authorization Details:

- **Authorization Number:** [Insert Number]
- **Effective Dates:** [Start Date] to [End Date]
- **Facility:** [Facility Name]

Upon completion of the multidisciplinary evaluation, please forward the comprehensive report and the surgical recommendation to our office for final review.

Sincerely,

[Signature]

[Printed Name and Title]

[Phone Number]

[Fax Number]