

**Date:** [Date]

**To:** Medical Director / Utilization Management Department

**Insurance Company:** [Insurance Company Name]

**Fax Number:** [Fax Number]

**RE: Request for Peer-to-Peer Review**

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Member ID:** [Member ID Number]

**Reference/Authorization Number:** [Denial Reference Number]

To Whom It May Concern,

I am writing to formally request a Peer-to-Peer review regarding the recent medical necessity denial for [Procedure Name, e.g., Roux-en-Y Gastric Bypass / Sleeve Gastrectomy] for the above-referenced patient.

I am the requesting surgeon and would like to discuss the clinical indicators, the patient's comorbid conditions, and their previous weight loss attempts that support the medical necessity of this procedure according to established clinical guidelines.

**Provider Availability:**

- [Option 1: Date and Time Range]
- [Option 2: Date and Time Range]
- [Option 3: Date and Time Range]

Please contact my office at [Phone Number] or via email at [Email Address] to confirm a scheduled time for this discussion. Alternatively, the reviewing medical director may reach me directly on my cell/backline at [Direct Number] during the windows listed above.

Thank you for your prompt attention to this matter.

Sincerely,

[Physician Name, MD/DO]

[Practice Name]

[Phone Number]