[Physician Name]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attn: Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Prior Authorization Request for Comprehensive Bariatric Evaluation
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request prior authorization for a comprehensive bariatric surgical evaluation for the above-referenced patient. [Patient Name] suffers from morbid obesity (ICD-10: [Code]) and has been under my care for weight management.

Clinical Documentation:

- **Current BMI:** [Current BMI]
- **Weight:** [Current Weight] lbs
- **Comorbidities:** [List conditions, e.g., Type 2 Diabetes, Hypertension, Obstructive Sleep Apnea]
- **Previous Interventions:** [List failed attempts, e.g., supervised diet, exercise programs, medications]

The requested evaluation will include multidisciplinary assessments from bariatric surgery, nutritional counseling, and psychological clearance to determine the patient's candidacy for bariatric intervention. This evaluation is medically necessary as the patient meets the clinical criteria for surgical consideration and has not achieved significant weight loss through conservative measures.

Please find the attached clinical notes and medical history supporting this request. We look forward to your timely response.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[NPI Number]