[Date]

[Insurance Company Name]
[Attn: Medical Review/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Bariatric Surgery

Patient Name: [Patient First and Last Name]
Policy Number: [Subscriber ID]
Group Number: [Group ID]
Date of Birth: [DOB]

To Whom It May Concern,

I am writing to formally request authorization for **[Type of Procedure, e.g., Gastric Bypass or Sleeve Gastrectomy]** (CPT Code: **[Code]**) for **[Patient Name]**. As the patient's **[Physician/Surgeon]**, I have determined that this procedure is medically necessary to treat morbid obesity and its associated life-threatening comorbidities.

The patient meets the clinical criteria for bariatric surgery based on the following medical profile:

- **Current BMI:** [Current BMI]
- **Height/Weight:** [Height] / [Weight]
- **Diagnosis:** Morbid Obesity (ICD-10: E66.01)

Comorbidities:
The patient suffers from the following obesity-related conditions:

- [Condition 1, e.g., Type 2 Diabetes] (ICD-10: [Code])
- [Condition 2, e.g., Obstructive Sleep Apnea] (ICD-10: [Code])
- [Condition 3, e.g., Hypertension] (ICD-10: [Code])

Previous Weight Loss Attempts:
The patient has made multiple documented attempts at weight loss through physician-supervised programs, including **[List programs, medications, or diets]** over a period of **[Number]** months/years. Despite these efforts, the patient has been unable to maintain significant weight loss.

Clinical Recommendation:
The patient has undergone a full multidisciplinary evaluation, including nutritional counseling and psychological screening. It is my professional opinion that without surgical intervention, the patient is at high risk for further health deterioration. This surgery is the most effective treatment to achieve long-term weight reduction and improvement of comorbid conditions.

Please review the attached medical records, including progress notes and laboratory results, which further document the medical necessity for this procedure. Please contact my office at **[Phone Number]** if you require additional information.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]