[Physician Name, MD/DO]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[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]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request authorization for [Procedure Type, e.g., Gastric Sleeve/Gastric Bypass] for my patient, [Patient Name]. This procedure is medically necessary to treat [Patient Name]'s morbid obesity and associated life-threatening comorbidities.

Clinical Findings:
The patient is [Age] years old with a current weight of [Weight] lbs and a height of [Height]. This results in a Body Mass Index (BMI) of [BMI].

Comorbidities:
The patient suffers from the following obesity-related conditions:
- [Condition 1, e.g., Type 2 Diabetes]
- [Condition 2, e.g., Obstructive Sleep Apnea]
- [Condition 3, e.g., Hypertension/High Cholesterol]

Weight Loss History:
[Patient Name] has made multiple unsuccessful attempts at weight loss through supervised programs, including [List programs, e.g., Weight Watchers, nutritional counseling, medications]. Despite these efforts, the patient has been unable to maintain significant weight loss.

Recommendation:
Based on the NIH guidelines and the patient's clinical history, I have determined that bariatric surgery is the most appropriate and effective treatment to reduce the risk of cardiovascular events and improve overall health outcomes. The patient has been evaluated by a multidisciplinary team and is cleared for surgery.

Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]
[Physician Name, Printed]