<u>SAMPLE LETTER OF MEDICAL NECESSITY:</u>

(Give this to your Primary Care Physician to complete and send to our office or give to You). This is required by most insurances for weight loss surgery insurance authorization.

Physican Letterhead OR
[insert name of practice]
[Insert physician name]
[insert address/contact information]

[insert date]

[insert insurance company name and address]

RE: [insert patient's name] Date of Birth:
Group #: ID#:

To Whom It May Concern:

Ms/Mr. [insert patient's name] has been a patient of mine for [insert number] years. Patient is (height) and weighs (weight) lbs. with a BMI of [insert patient's BMI]. Patient has been excessively overweight for some time now and will benefit from Bariatric surgery.

In addition to morbid obesity, the patient is suffering from the following comorbid conditions: [insert comorbidities, e.g. exertional dyspnea, urinary incontinence, sleep apnea, hypertension, diabetes, degenerative joint disease, osteoarthritis, hypercholesterolemia, hyperlipidemia, shortness of breath, etc].

Patient has tried many methods of weight loss including diet pills for [insert length of time] with [insert number of pounds lost and whether they were regained or not], physician-administered diets for [insert length of time] with [insert number of pounds lost and whether they were regained or not], WeightWatchers, etc. The patient is limited due to her comorbidities in her ability to exercise but has tried [list all attempts and any successes or regaining of weight].

Family medical history is positive for [insert medical conditions, e.g. obesity, hypertension, diabetes, hypercholesterolemia, etc].

I am respectfully requesting pre-authorization for Bariatric surgery to include patient's benefits and coverage. Thank you for your kind consideration in this matter.

Sincerely,

[Physician Name]