
Sample Letter of Medical Necessity

[insert date]

[insert insurance company name and address]

RE: [insert patient name]

[Insert patient's date of birth]

ID#:

GROUP #:

To whom it may concern:

Ms./Mr./Mrs. [insert patient's name] has been a patient of mine for [insert #] years. Patient is [insert height] and weighs [insert weight] lbs, which calculates to a BMI of [insert 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 co-morbidities: [insert, as appropriate: external dyspnea, sleep apnea, hypertension, diabetes, etc.]

Patient has tried many methods of weight loss, including: [list previous weight loss attempts].

Family medical history is positive for: [list relevant family medical history].

I am respectfully requesting pre-authorization for bariatric surgery for [patient's name]. Thank you for your kind consideration in this matter.

Sincerely,

[Physician's name]
