



GEORGIA REGENTS  
CENTER FOR  
OBESITY & METABOLISM

## Sample Letter of Medical Necessity

Give this to your Primary Care Physician for him/her to fill out.

(Name of practice)  
(Name of physician, MD)  
(Insert address/contact information)

Date:  
Insurance company name and address  
RE: patient name  
Date of birth  
Group #  
ID#

To whom it may concern:

Ms/Mr. (insert patient name) has been a patient of mine for (insert number) of years. The patient is (height) and weighs (weight) pounds with a BMI of (insert BMI). The patient has been excessively overweight for \_\_\_ years now and will benefit from bariatric surgery.

Last 5 year weight history: (insert last 5 year weight history)

In addition to morbid obesity, the patient is suffering from the following co-morbid conditions: (list all conditions; examples include exertional dyspnea, urinary incontinence, sleep apnea, hypertension, diabetes, degenerative joint disease, osteoarthritis, hypercholesterolemia, hyperlipidemia, shortness of breath, etc).

The patient has tried many methods of weight loss including diet pills for (insert length of time) with (insert # of pounds lost and whether they were regained or not), physician-administered diets for (insert length of time) with (insert # of pounds lost and if they regained or not), Weight Watchers, etc. The patient is limited due to his/her co-morbidities and inability to exercise but has tried (list all attempts and any successes or regaining of weight).

Family medical history is positive for (insert medical conditions; hypertension, diabetes, etc).  
I am respectfully requesting pre-authorization for bariatric surgery to include patient's benefits and coverage. The patient is medically cleared for surgery. Thank you for your consideration in this matter.

Sincerely,

Physician name, MD

Please fax to Georgia Regents Weight Loss Center at 706-721-7524 or  
Mail to: Georgia Regents Weight Loss Center, 1120 15<sup>th</sup> Street, BI4074A, Augusta, GA 30912