TEMPLATE FOR A LETTER OF MEDICAL NECESSITY FOR BARIATRIC SURGERY INCLUDING REQUIRED MEDICAL CLEARANCE

*A Letter of Medical Necessity (LMN) is **required** by insurance companies. It is a statement written by a patient's primary care physician (PCP) describing a patient's health condition and the reasons why bariatric surgery is the medically necessary treatment. Medical clearance is also required prior to bariatric surgery, and if you haven't had a complete physical exam recently you should schedule one. Your PCP will require a complete physical before giving medical clearance.*

*The **minimum** components of the letter include a patient's weight & body mass index (BMI), how many years the patient has been obese, overall health, obesity co-morbidities, previous weight loss attempts, & health history. It includes a statement that the patient is medically cleared for surgery. The letter **must** document that the physician believes that the patient understands the risks, has reasonable expectations of the surgery & that the patient is willing & able to comply with the post- operative requirements. Lastly, the letter states the provider's recommendation for bariatric surgery as the medically necessary method of treatment. This letter must be typed on the PCP's letterhead and signed by the physician.*

This letter template includes all of the required components of the LMN & medical clearance. It should be printed and taken to an appointment with your PCP.

[Date]

Re: *[patient's name]*
Date of Birth:

To whom it may concern:

[Patient's name] has been a patient of mine for *[insert number]* years. Patient is *[insert height]* tall and weighs [*insert weight]* pounds for a calculated BMI of *[insert number]*. This patient has been excessively overweight for the last [*insert number of years]* and will benefit from Bariatric surgery.

The patient is medically cleared for surgery. An EKG *[also insert names of other tests included such as laboratory tests, stress test, echocardiogram, sleep study and/or PFT]* is provided with this letter.

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

The patient has tried many methods of weight loss including appetite suppressants for *[IF appetite suppressants were tried - insert length of time]*, with *[insert number of pounds lost and whether they were regained or not]*, physician-administered diet plans for *[insert length of time]* and *[insert number of pounds lost and whether they were regained or not]*, *Weight Watchers, etc.* The patient is limited due to his/her co-morbidities in his/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 supportive of this patient's desire to proceed with Bariatric surgery. The patient has a good understanding of the risks involved and reasonable expectations and understands the importance of being compliant with all post-surgical requirements. I will also continue to support this patient's primary care needs should they proceed with surgical intervention. I am respectfully requesting consideration for Bariatric surgery.

Thank you for your attention in this matter.

Sincerely,

[Signature and typed name of PCP]