[Date]

To: [Insurance Company Name]
Attention: Prior Authorization Department / Medical Review
Fax/Address: [Fax Number or Mailing Address]

RE: Prior Authorization Request for Psychological Evaluation (CPT 90791 / 96130)
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request prior authorization for a pre-surgical psychological evaluation for the above-referenced patient. This evaluation is a clinical requirement to determine the patient's psychological readiness for bariatric surgery (ICD-10: E66.01, Morbid Obesity).

The evaluation will assess the following areas as required by clinical protocols:

- Understanding of the surgical procedure and necessary lifestyle changes.
- History of psychiatric disorders and current mental health status.
- Eating behaviors and history of disordered eating.
- Social support systems and environmental stability.
- Substance use history.
- Adherence potential to post-operative medical and nutritional regimens.

Provider Information:
Evaluating Psychologist: [Provider Name, Degree]
NPI Number: [NPI Number]
Tax ID: [Tax ID Number]
Clinic Address: [Address, City, State, Zip]
Phone Number: [Phone Number]

This evaluation is medically necessary to ensure the best possible surgical outcome and long-term success for the patient. Please provide a determination regarding this authorization request at your earliest convenience.

Sincerely,

[Provider Signature]
[Printed Name and Credentials]