[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Prior Authorization Request for Nutritional Assessment

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Provider Name: [Physician Name]

To Whom It May Concern,

I am writing to request a prior authorization for a comprehensive nutritional assessment for the above-referenced patient. This assessment is medically necessary to evaluate and manage the patient's current health status.

Clinical Justification:

- **Diagnosis:** [Primary Diagnosis/ICD-10 Code]
- **Symptoms/Clinical Indicators:** [e.g., Unintentional weight loss, malnutrition, chronic disease management, etc.]
- **Treatment Plan:** A registered dietitian is required to assess caloric needs, nutrient deficiencies, and develop a medical nutrition therapy plan to prevent further complications.

Requested Service Details:

- **CPT Code(s):** [e.g., 97802 or 97803]
- **Frequency:** [Number of sessions requested]
- **Facility/Provider:** [Provider Name/Facility Name]

Included with this letter are the patient's relevant medical records and laboratory results supporting this request. Please contact my office at [Phone Number] if you require additional information.

Thank you for your prompt attention to this matter.

Sincerely,

[Provider Signature]
[Provider Printed Name]

[NPI Number]
[Practice Name]