Date: [Date]

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

RE: Letter of Medical Necessity for Diagnostic Consultation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group ID]

To Whom It May Concern,

I am writing to request authorization for a rheumatology diagnostic consultation and comprehensive autoimmune evaluation for the above-referenced patient. Based on the patient's clinical presentation and preliminary findings, a specialist evaluation is medically necessary to rule out or confirm a systemic autoimmune or rheumatic disease.

Clinical History and Symptoms:
The patient has presented with the following persistent symptoms for [Duration]:
[List symptoms, e.g., chronic joint pain, swelling, morning stiffness, malar rash, Raynaud's phenomenon, unexplained fevers, or fatigue].

Preliminary Laboratory/Imaging Findings:
Initial screening indicated the following abnormalities:
[List findings, e.g., Elevated ANA titer, Positive RF, High CRP/ESR, Positive Anti-CCP, or specific imaging results].

Medical Necessity:
The requested consultation is essential to prevent permanent joint damage, organ involvement, or disease progression. A formal diagnosis by a rheumatologist is required to establish a targeted treatment plan, which may include Disease-Modifying Antirheumatic Drugs (DMARDs) or biologic therapies.

Requested Services:
- Initial Specialist Consultation (CPT 99204/99205)
- Comprehensive Autoimmune Serology Panel
- Diagnostic Imaging (if applicable)

Please contact my office at [Phone Number] if further documentation is required to expedite this approval.

Sincerely,

[Physician Name, MD/DO]
[NPI Number]
[Practice Name]