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

RE: Request for Prior Authorization for Genetic Consultation

Patient Information:
Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request prior authorization for a genetic consultation for the above-named patient. This consultation is scheduled to take place on [Date] with [Provider Name] at [Facility Name].

Clinical Justification:
The patient is being referred for genetic counseling due to the following medical necessity:

- [Insert primary diagnosis or ICD-10 code]
- [Insert relevant personal or family medical history]
- [Reason why genetic testing results will impact clinical management]

The purpose of this consultation is to assess the patient's risk for hereditary conditions, discuss the benefits and limitations of specific genetic tests, and provide informed consent. A professional genetic assessment is a critical step in determining the most cost-effective and clinically appropriate testing strategy.

Requested Service:
CPT Code: 96040 (Genetic counseling, each 30 minutes) or [Insert alternative CPT code]

Please review this request for medical necessity. If you require further documentation, such as clinical notes or family pedigrees, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, Title]
[NPI Number]
[Practice Name]