[Date]

[Insurance Company Name]
[Claims/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Gender-Affirming Surgery
Patient Name: [Patient Full Name]
Patient Date of Birth: [DOB]
Policy Number: [Policy Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing this letter to formally provide documentation of medical necessity for [Patient Name] to undergo [Specific Procedure Name, e.g., Bilateral Mastectomy and Male Chest Reconstruction] (CPT Code: [CPT Code]).

I have been treating [Patient Name] since [Date]. I have diagnosed the patient with Gender Dysphoria (ICD-10: F64.1). This patient meets the criteria for surgery as outlined in the WPATH Standards of Care:

- The patient has a persistent, well-documented history of gender dysphoria.
- The patient has the capacity to make a fully informed decision and to consent for treatment.
- The patient is of the age of majority.
- Any significant medical or mental health concerns are reasonably well-controlled.

The patient has lived in a gender role congruent with their gender identity for [Number] years/months. [Patient Name] reports significant distress related to their chest, which interferes with daily functioning and social integration. The requested surgical intervention is the next appropriate step in the patient's transition and is not considered cosmetic, but rather a medically necessary treatment to alleviate the symptoms of Gender Dysphoria.

I fully support [Patient Name]'s decision to pursue this surgery and believe it is essential for their long-term health and well-being. Please feel free to contact me at [Phone Number] or [Email Address] if you require further information.

Sincerely,

[Provider Signature]
[Provider Printed Name and Credentials]
[License Number]
[Practice Name/Clinic]