[Date]
[Insurance Company Name]
[Insurance 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: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing this letter to support [Patient Name]'s request for [Specific Procedure Name, e.g., Vaginoplasty/Phalloplasty]. I am a [License Type, e.g., Licensed Clinical Social Worker/MD] and have been treating the patient since [Start Date].

The patient has been diagnosed with Gender Dysphoria (ICD-10 F64.0). [Patient Name] has a long-standing history of gender incongruence and has been living full-time in a gender role congruent with their gender identity for [Number] years. They have also undergone continuous hormone replacement therapy for [Number] months/years.

The patient meets the criteria for surgery as outlined by the WPATH Standards of Care:

- Persistent, well-documented gender dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Age of majority.
- Significant medical or mental health concerns, if present, are reasonably well-controlled.
- Completion of 12 months of continuous hormone therapy (unless contraindicated).
- Completion of 12 months of living in a gender role that is congruent with their gender identity.

The requested surgical procedure is not cosmetic; it is a medically necessary treatment to alleviate the profound distress caused by gender dysphoria. Without this intervention, the patient remains at risk for worsening mental health symptoms.

I fully recommend [Patient Name] for gender-affirming bottom surgery. If you require further information, please contact me at [Phone Number] or [Email].

Sincerely,

[Signature]
[Printed Name and Credentials]
[License Number]
[NPI Number]
[Clinic Name]