[Physician Name, MD/DO/PhD]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To: [Insurance Company Name]
Attn: [Appeals/Authorization Department]
[Insurance Address]
[City, State, Zip Code]

Re: Letter of Medical Necessity for Facial Feminization Surgery (FFS)

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

To Whom It May Concern:

I am writing this letter to support the medical necessity of Facial Feminization Surgery (FFS) for [Patient Name]. [Patient Name] has been under my care since [Date] and carries a formal diagnosis of Gender Dysphoria (ICD-10 F64.0).

Per the WPATH Standards of Care, I have determined that the following procedures are medically necessary to treat the patient's gender dysphoria: [List procedures, e.g., Brow Lift, Rhinoplasty, Mandible Contouring, Tracheal Shave].

The patient has met the following clinical criteria:

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Age of majority.
- If significant medical or mental health concerns are present, they must be reasonably well-controlled.
- [Optional: The patient has completed 12+ months of continuous hormone replacement therapy].

For [Patient Name], the presence of secondary sex characteristics perceived as masculine is a source of severe clinically significant distress. This facial structure prevents the patient from successfully transitioning and increases the risk of harassment and discrimination. These surgeries are not cosmetic; they are reconstructive procedures intended to align the patient's physical appearance with their gender identity.

I strongly recommend that you approve coverage for these procedures to ensure the health and well-being of the patient. Please contact me at [Phone Number] if you require further documentation.

Sincerely,

[Signature]

[Printed Name and Title]
[License Number/NPI]