[Date]

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

RE: Letter of Medical Necessity for Chondrolaryngoplasty

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, **[Patient Name]**, to request prior authorization and coverage for a Chondrolaryngoplasty (CPT Code: 31599 or 31899). This procedure is medically necessary to treat Gender Dysphoria (ICD-10: F64.0).

Patient Clinical History:
[Patient Name] is a [Age]-year-old individual who has been under my care for [Duration of Time]. The patient has a persistent and well-documented diagnosis of Gender Dysphoria. As part of their gender transition, the patient has undergone the following treatments:

- Continuous Hormone Replacement Therapy (HRT) since [Date].
- Mental health counseling for [Duration].
- Living in a gender role congruent with their identity since [Date].

Medical Necessity:
Despite the aforementioned treatments, the patient suffers from significant distress caused by a prominent laryngeal prominence (Adam's Apple). This secondary sex characteristic is a source of severe gender incongruence and social dysphoria. The presence of this physical feature frequently leads to "misgendering," which significantly impacts the patient's mental health, safety, and ability to function in professional and social environments.

Clinical Recommendation:
Chondrolaryngoplasty is not a cosmetic procedure for this patient; it is a reconstructive surgery aimed at aligning the patient's physical appearance with their gender identity. This treatment follows the World Professional Association for Transgender Health (WPATH) Standards of Care. Failure to perform this procedure would likely result in the exacerbation of the patient's dysphoria and related mental health symptoms.

I strongly recommend that you approve coverage for this medically necessary procedure. Please contact my office at [Phone Number] if you require further documentation or clinical records.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Board Certification]
[Medical License Number]
[Practice Name/Hospital]