[Date]

[Insurance Company Name]
[Insurance Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Augmentation Mammoplasty
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Member ID]
Group Number: [Group ID]

To Whom It May Concern,

I am writing this letter to support the medical necessity of feminizing augmentation mammoplasty for [Patient Name] as a treatment for Gender Dysphoria (ICD-10 F64.0).

Clinical History:
[Patient Name] has been under my care since [Date]. They have a persistent and well-documented diagnosis of Gender Dysphoria. The patient has been living full-time in a gender role congruent with their female identity for [Number] years/months. Furthermore, the patient has undergone continuous feminizing hormone replacement therapy (HRT) for [Number] months/years.

Clinical Findings:
Despite compliant hormone therapy, the patient has experienced negligible breast development (Tanner Stage [X]). The lack of breast growth continues to cause significant clinical distress, impairment in social and occupational functioning, and severe gender dysphoria.

Medical Necessity:
The requested procedure, Augmentation Mammoplasty (CPT 19325), is not cosmetic in this case. It is a reconstructive procedure to treat a diagnosed medical condition. This treatment follows the World Professional Association for Transgender Health (WPATH) Standards of Care. [Patient Name] has the capacity to make fully informed decisions and has consented to treatment. They have no co-existing mental health or medical conditions that would contraindicate this surgery.

In conclusion, feminizing breast augmentation is an essential component of the transition-related healthcare for [Patient Name]. I strongly recommend that this procedure be approved as a medically necessary treatment.

Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Provider Signature]

[Provider Name, Credentials]
[NPI Number]
[Practice Name]