[Date]

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

RE: Letter of Medical Necessity for Gender-Affirming Surgery
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 [Patient Name]'s request for a gender-affirming hysterectomy and bilateral salpingo-oophorectomy (CPT Codes: [Insert Codes]). I have been [Patient Name]'s treating [Physician/Provider Type] since [Date].

[Patient Name] has a diagnosis of Gender Dysphoria (ICD-10: F64.0). This patient has lived in a gender role congruent with their gender identity for [Number] years and has been on continuous hormone replacement therapy for [Number] months/years. The patient expresses a persistent and well-documented desire for this surgical intervention to alleviate the symptoms of gender dysphoria.

I have evaluated [Patient Name] and confirm the following:

- The patient has the capacity to make fully informed decisions and has consented to treatment.
- The patient has reached the age of majority.
- Any significant medical or mental health concerns are reasonably well-controlled.
- The patient experiences significant distress due to their reproductive anatomy, which interferes with daily functioning.

This procedure is not cosmetic. It is a medically necessary treatment for [Patient Name]'s gender dysphoria, consistent with the World Professional Association for Transgender Health (WPATH) Standards of Care. Without this surgery, the patient's health and well-being are at risk.

I highly recommend that [Patient Name] be approved for this procedure as soon as possible. Please contact me at [Phone Number] or [Email] if you require further documentation.

Sincerely,

[Signature]
[Provider Name, Credentials]

[License Number/NPI]
[Clinic Name]