[Date]

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

RE: Letter of Medical Necessity for Genetic Testing

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request coverage for hereditary cancer genetic testing (specifically BRCA1/BRCA2 and/or a multi-gene panel) for my patient, [Patient Name]. Based on the patient's personal and/or family medical history, this testing is medically necessary to assess the risk of Hereditary Breast and Ovarian Cancer (HBOC) syndrome.

Clinical Indications:

The patient meets the following criteria for testing:

- [Example: Personal history of breast cancer diagnosed at age 45]
- [Example: Family history of ovarian cancer (maternal aunt)]
- [Example: Known pathogenic mutation in the family]
- [Example: Ashkenazi Jewish ancestry]

Medical Necessity:

The results of this genetic test will directly impact the patient's clinical management. Depending on the results, the following interventions may be recommended:

- Increased frequency of breast cancer screening (e.g., Breast MRI).
- Discussion of risk-reducing medications (chemoprevention).
- Evaluation for prophylactic surgical options (e.g., bilateral salpingo-oophorectomy or mastectomy).
- Informing at-risk family members of their potential genetic risk.

This request is consistent with current National Comprehensive Cancer Network (NCCN) guidelines regarding genetic testing for hereditary cancer syndromes.

I request that you authorize coverage for CPT code(s): [Insert CPT Codes, e.g., 81162, 81432].

Thank you for your prompt review of this request. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Name]
[Title]
[NPI Number]
[Clinic/Hospital Name]