Date: [Date]

To: [Insurance Company Name]
Attention: Medical Review/Appeals Department
Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Prenatal Carrier Screening

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

To Whom It May Concern,

I am writing to request coverage for expanded carrier screening for my patient, [Patient Name], who is currently [pregnant / planning a pregnancy]. I have ordered the [Name of Test] provided by [Laboratory Name].

Clinical Justification:
The patient is being screened for autosomal recessive and X-linked genetic conditions. This testing is medically necessary for the following reasons:

- **Standard of Care:** Professional organizations, including ACOG and ACMG, recommend that carrier screening for genetic conditions be offered to all pregnant women or those considering pregnancy, regardless of ethnicity.
- **Risk Assessment:** Identifying the carrier status of the patient is the first step in determining the risk of the fetus inheriting a serious, life-limiting, or debilitating genetic disorder.
- **Informed Management:** The results of this screening will directly influence the clinical management of this pregnancy, including options for prenatal diagnosis, specialized delivery care, and immediate neonatal intervention.
- **Family History/Ethnicity:** [Optional: Mention specific ethnic risk factors or family history of genetic disorders here].

Relevant ICD-10 Codes:
[Insert Code, e.g., Z31.430 - Encounter of female for testing for genetic disease carrier status for procreative management]

Based on the patient's clinical profile and current medical guidelines, I request that you approve coverage for this essential diagnostic test. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]