Date: [Date]

TO: [Insurance Company Name]
ATTN: Medical Review/Prior Authorization Department
FAX/ADDRESS: [Fax Number or Address]

RE: Letter of Medical Necessity for Genetic Testing
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy ID: [Member ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request coverage for hereditary cardiovascular disease genetic testing for [Patient Name]. Based on the patient's personal and family medical history, this testing is medically necessary to guide clinical management and risk assessment.

Clinical Indications:
[Patient Name] presents with a clinical diagnosis or high suspicion of [Specific Condition, e.g., Hypertrophic Cardiomyopathy, Long QT Syndrome, Familial Hypercholesterolemia].

Relevant History:
The patient's history includes:

- [List specific symptoms, e.g., unexplained cardiac arrest, syncope, early-onset heart failure]
- [List family history, e.g., sudden cardiac death in a first-degree relative at age 35]

Requested Test:
The requested test is [Name of Specific Genetic Test/Panel, e.g., Comprehensive Arrhythmia Panel] (CPT Code: [Insert Code]).

Medical Necessity:
The results of this genetic test will directly impact the patient's treatment plan in the following ways:

- Refining the clinical diagnosis and identifying the specific underlying genetic cause.
- Determining the necessity of surgical interventions (e.g., ICD or pacemaker implantation).
- Informing pharmacological management and avoidance of specific medications.
- Identifying at-risk family members who require targeted screening or preventive care.

I request that you approve coverage for this testing. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Name]
[NPI Number]
[Facility Name]