Date: [Date]

To: [Insurance Company Name]
Attention: Medical Review/Prior Authorization Department
Address: [Insurance Company Address]

RE: Letter of Medical Necessity for Genetic Testing

Patient Name: [Patient Name]
Date of Birth: [Date of Birth]
Policy Number: [Policy Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request coverage for genetic testing for Lynch Syndrome (Hereditary Non-Polyposis Colorectal Cancer) for my patient, [Patient Name]. Specifically, I am ordering [Insert Name of Test/Panel, e.g., Multi-gene panel including MLH1, MSH2, MSH6, PMS2, and EPCAM].

Clinical Justification:
[Patient Name] meets the clinical criteria for this testing based on the following factors:

- [Include personal history of colorectal or related cancers, including age at diagnosis]
- [Include family history of Lynch-associated cancers, specifying relationship and age of onset]
- [Mention results of MSI or IHC screening on tumor tissue, if applicable]
- [Reference specific criteria met, e.g., Revised Bethesda Guidelines or NCCN Guidelines]

Medical Necessity:
The results of this genetic test are vital to the clinical management of this patient. A diagnosis of Lynch Syndrome would significantly alter the medical management plan, including:

- Increased frequency of colonoscopy surveillance (every 1-2 years).
- Screening for extra-colonic cancers (endometrial, ovarian, gastric, etc.).
- Consideration of prophylactic surgical options.
- Informing risk assessment for biological family members.

In summary, this testing is medically necessary to provide appropriate preventative care and risk reduction for [Patient Name]. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[NPI Number]
[Practice Name]