**Date:** [Date]

**To:** [Insurance Company Name]
**Attention:** Medical Review/Appeals Department
**Address:** [Insurance Company Address]

**RE: Letter of Medical Necessity for Non-Invasive Prenatal Testing (NIPT)**

**Patient Name:** [Patient Full Name]
**Date of Birth:** [Patient DOB]
**Policy Number:** [Policy Number]
**Group Number:** [Group Number]
**Case Reference Number:** [If applicable]

To Whom It May Concern,

I am writing to request coverage for Non-Invasive Prenatal Testing (NIPT) for my patient, [Patient Name], who is currently at [Number] weeks of gestation. This test is being ordered to screen for fetal chromosomal aneuploidies, including Trisomy 21, 18, and 13.

NIPT is medically necessary for this patient based on the following clinical indications:

- [Advanced maternal age (35 years or older at delivery)]
- [Abnormal ultrasound findings]
- [History of a prior pregnancy with a chromosomal abnormality]
- [Positive result from a different screening test, such as first-trimester screen]
- [Other: Specific clinical reason or high-risk factor]

The relevant ICD-10 diagnosis codes for this patient include:

- [Code 1, e.g., Z36.89 - Encounter for other antenatal screening]
- [Code 2, e.g., O09.519 - Supervision of elderly primigravida]

NIPT is a highly sensitive and specific screening tool that significantly reduces the need for invasive procedures such as amniocentesis or chorionic villus sampling (CVS), which carry a risk of miscarriage. Professional organizations, including ACOG and ACMG, support NIPT as a screening option for all pregnant women regardless of baseline risk.

Based on the clinical history provided, I request that you approve coverage for this essential prenatal screening. Should you require additional documentation, please contact my office at [Phone Number].

Sincerely,

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

[Medical Practice Name]
[NPI Number]