Date: [Date]
To: [Insurance Company Name]
Attention: Medical Review/Prior Authorization Department
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy ID: [Member ID Number]
Group Number: [Group Number]

Subject: Letter of Medical Necessity for Genetic Testing

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request coverage for [Type of Genetic Test, e.g., Whole Exome Sequencing or Chromosomal Microarray]. This patient has been diagnosed with global developmental delay and [List other diagnoses, e.g., speech delay, hypotonia, or dysmorphic features].

Clinical History and Findings:
[Patient Name] is a [Age]-old child who presents with the following clinical symptoms:

- [Symptom 1: e.g., Failure to meet motor milestones]
- [Symptom 2: e.g., Significant expressive language delay]
- [Symptom 3: e.g., Congenital anomalies]

Rationale for Testing:
Genetic testing is medically necessary at this time for the following reasons:

- **Definitive Diagnosis:** To identify the underlying genetic etiology of the developmental delay.
- **Clinical Management:** A diagnosis will direct specific medical surveillance, identify potential co-morbidities, and prevent unnecessary future diagnostic procedures.
- **Standard of Care:** The American Academy of Pediatrics (AAP) and the American College of Medical Genetics (ACMG) recommend genetic evaluation as a first-tier or secondary diagnostic step for children with unexplained developmental delays.

In summary, the requested genetic testing is essential for the clinical management of [Patient Name]. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Specialty]
[Practice Name]
[NPI Number]