Date: [Date]

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

RE: Letter of Medical Necessity for Thrombophilia Genetic Screening

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

To Whom It May Concern,

I am writing to request coverage for thrombophilia genetic risk screening for the above-mentioned patient. This testing is medically necessary to guide clinical management and prevent future life-threatening thrombotic events.

Patient Clinical History:
The patient meets the clinical criteria for testing based on the following (check all that apply):
[ ] Personal history of unprovoked Venous Thromboembolism (VTE) at age [Age].
[ ] Recurrent Venous Thromboembolism.
[ ] History of blood clots in atypical sites (e.g., cerebral, hepatic, or mesenteric veins).
[ ] Family history of VTE in a first-degree relative before age 50.
[ ] History of pregnancy-related complications (e.g., recurrent pregnancy loss, preeclampsia, or placental abruption).
[ ] Use of estrogen-containing medications with a high-risk profile.

Requested Testing:
I have ordered the following genetic evaluations:
- Factor V Leiden (G1691A) Mutation
- Prothrombin (Factor II) G20210A Mutation
- [Other: Protein C, Protein S, or Antithrombin III levels]

Clinical Utility:
The results of this screening will directly influence the patient's treatment plan, including the duration of anticoagulant therapy, prophylactic measures during high-risk periods (surgery, pregnancy, or immobilization), and counseling regarding hormonal medications. Identifying these genetic markers is essential for risk stratification and the prevention of future morbidity.

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

Sincerely,

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