

**Date:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** Appeals/Medical Review Department

**ADDRESS:** [Insurance Company Address]

**RE:** Letter of Medical Necessity for Out-of-Network Referral

**Patient Name:** [Patient Name]

**Date of Birth:** [Patient DOB]

**Member ID:** [Member ID Number]

**Claim/Reference Number:** [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally request an out-of-network referral and "network gap exception" for [Patient Name] to receive care from [Out-of-Network Specialist Name], located at [Specialist Address]. This request is based on the geographic unavailability of a qualified in-network provider capable of treating the patient's specific medical condition.

**Medical Diagnosis:**

The patient has been diagnosed with [Diagnosis/ICD-10 Code]. This condition requires specialized treatment in the field of [Specialty].

**Reason for Out-of-Network Request:**

After a thorough review of the current provider directory and consultation with the insurance network, it has been determined that there are no in-network specialists within a reasonable geographic distance (defined as [Number] miles/minutes) from the patient's residence who possess the necessary expertise to manage this case. The nearest in-network provider is located [Number] miles away, which poses an undue hardship and a risk to the continuity of necessary care.

**Clinical Necessity:**

[Out-of-Network Specialist Name] is uniquely qualified to provide [Specific Treatment/Procedure]. Delaying treatment or requiring the patient to travel beyond a reasonable geographic area would [explain risk, e.g., result in clinical deterioration].

**Request:**

I request that [Insurance Company Name] authorize treatment with [Specialist Name] at the in-network benefit level (including in-network cost-sharing and out-of-pocket maximums) due to the lack of available local providers.

Thank you for your prompt attention to this matter. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Practice Name]

[NPI Number]