[Date]

[Insurance Company Name]
[Attn: Appeals/Grievance Department]
[Insurance Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Out-of-Network Referral
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Requested Specialist: [Surgeon Name and Practice]

To Whom It May Concern,

I am writing to formally request an out-of-network referral and coverage at the in-network benefit level for [Patient Name] to undergo [Specific Surgical Procedure] with [Surgeon Name].

Clinical Diagnosis:
[Patient Name] has been diagnosed with [Diagnosis/ICD-10 Code]. This condition is characterized by [Brief description of symptoms and severity].

Medical Necessity:
The requested surgical specialist possesses unique expertise in [Specific Technique or Rare Condition] that is necessary for the successful treatment of this patient. Previous conservative treatments, including [List treatments like PT, medications, or failed minor surgeries], have been exhausted without success.

Network Inadequacy:
I have reviewed the current provider directory and determined that there are no in-network surgeons within a reasonable geographic distance who possess the specialized skills or equipment required to perform this specific complex procedure. Delaying this surgery or utilizing a less experienced provider poses a significant risk of [List risks: e.g., permanent disability, worsening of condition].

Requested Action:
Based on the clinical complexity of this case, I request that you authorize [Surgeon Name] as an out-of-network provider for this procedure and apply the in-network cost-sharing, deductible, and out-of-pocket maximums.

Supporting medical records, imaging reports, and the surgeon's clinical notes are attached for your review.

Sincerely,

[Referring Physician Signature]
[Referring Physician Name, MD/DO]
[Practice Name]
[Phone Number]