[Physician Name]
[Physician Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

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

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

To Whom It May Concern,

I am writing to formally request a referral and coverage for [Patient Name] to receive oncology treatment from [Specialist Name] at [Out-of-Network Facility/Institution]. This request is based on medical necessity due to the complexity of the patient's diagnosis and the lack of comparable expertise within the current provider network.

Clinical Diagnosis:
The patient has been diagnosed with [Specific Diagnosis and Stage/ICD-10 Code]. [Include brief history of treatment or recent progression].

Reason for Out-of-Network Referral:
The requested specialist provides a specific level of care and expertise required for this case that is unavailable in-network for the following reasons:

- [Reason 1: e.g., Rare subtype of cancer requiring sub-specialized knowledge]
- [Reason 2: e.g., Access to specific clinical trials or unique surgical technology]
- [Reason 3: e.g., Failure of standard treatments available at in-network facilities]

Medical Necessity:
Treating the patient within the current network would likely result in [potential negative outcomes, e.g., delay in care, suboptimal treatment outcomes]. [Specialist Name] is uniquely qualified to manage this patient's complex needs because [reason].

I request that you authorize this out-of-network referral at the in-network benefit level to ensure the patient receives the standard of care required for their condition. I have attached relevant medical records and pathology reports to support this request.

Should you require further clinical information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]