

[Date]

[Insurance Company Name]
[Claims/Appeals Department Address]
[City, State, Zip Code]

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

Patient Name: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Policy Number: [ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request a referral and coverage for [Patient Name] to see an out-of-network neurology specialist, [Specialist Name], at [Clinic/Institution Name].

Clinical Diagnosis:

[Patient Name] has been diagnosed with [Diagnosis/ICD-10 Code]. This is a complex neurological condition characterized by [Brief symptoms or severity].

Medical Necessity:

The patient requires specialized care that cannot be adequately provided by the providers currently within the [Insurance Company Name] network. Specifically, the patient requires [Specific Treatment, Surgery, or Diagnostic Tool] which is only available through [Specialist Name].

In-Network Limitations:

We have reviewed the current provider directory and determined that there are no in-network neurologists within a reasonable distance who possess the sub-specialty expertise in [Specific Sub-specialty, e.g., Neuromuscular Disorders, Intractable Epilepsy] required to manage this case safely and effectively.

Treatment History:

To date, the patient has attempted the following in-network treatments without success:

- [Previous Treatment/Medication 1] - [Result]
- [Previous Treatment/Medication 2] - [Result]

Failure to provide access to this specialist may result in [Potential complication or worsening of condition]. Therefore, I request that you authorize this out-of-network consultation at the in-network benefit level.

Please contact my office at [Phone Number] if you require additional medical records or documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice Name]

[NPI Number]