

[Date]

[Insurance Company Name]  
[Attn: Medical Review/Appeals 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]

**Policy ID Number:** [ID Number]

**Group Number:** [Group Number]

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

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request an out-of-network referral and coverage at the in-network benefit level for advanced therapy services provided by [Specialist Name/Facility Name].

**Clinical Diagnosis and History:**

The patient has been diagnosed with [Diagnosis/ICD-10 Code]. This condition is characterized by [Brief description of severity and symptoms]. To date, the patient has undergone the following treatments without success: [List previous treatments, surgeries, or medications].

**Medical Necessity for Advanced Therapy:**

The patient requires [Specific Therapy Name]. This intervention is medically necessary because [Reason why this specific therapy is required]. Delay in receiving this specialized care may result in [Potential negative health outcomes].

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

I am requesting this out-of-network referral because [Select appropriate reason: there are no qualified in-network providers within a reasonable distance / the patient requires a specific expertise not available in-network / previous in-network treatments have been exhausted]. [Specialist Name] possesses unique expertise in [Specific technique or clinical trial] that is critical for the patient's management.

**Proposed Treatment Plan:**

The requested plan includes [Number of sessions/Duration of treatment] at a projected cost of [Estimate, if known].

I request that you approve this out-of-network referral to ensure [Patient Name] receives the standard of care required for their condition. Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/Specialty]

[NPI Number]

[Practice Name]

[Contact Information]