[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 First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

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 be evaluated by [Specialist Name] at [Facility Name].

Clinical History and Diagnosis:
[Patient Name] presents with [List primary symptoms, diagnosis, or suspected genetic condition]. Given the complexity of this presentation, specialized genetic evaluation and testing are medically necessary to establish a definitive diagnosis, guide clinical management, and prevent future complications.

Medical Necessity for Out-of-Network Provider:
I am requesting this referral to [Specialist Name] because they possess unique expertise in [Specific Genetic Sub-specialty, e.g., Metabolic Disorders or Neurogenetics] that is not available within the current provider network. After reviewing the network directory, I have determined that there are no in-network specialists within a reasonable geographic distance who possess the necessary expertise to manage this specific condition.

Treatment Plan:
The evaluation by [Specialist Name] will include [List planned services, e.g., comprehensive physical exam, genetic counseling, and specific genetic sequencing]. The results of this consultation are vital for determining [List outcomes, e.g., medication adjustments, surgical interventions, or specialized monitoring].

Delay in accessing this specialized care may result in [List risks, e.g., permanent disability, misdiagnosis, or avoidable hospitalizations].

I request that you authorize this out-of-network consultation to ensure [Patient Name] receives the standard of care required for their complex condition. Please contact my office at [Phone Number] if you require additional medical records or documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[NPI Number]
[Practice Name]
[Phone Number]