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

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 treated by [Out-of-Network Specialist Name], a Maternal-Fetal Medicine (High-Risk Obstetrics) specialist at [Facility Name].

The patient is currently [Number] weeks pregnant and has been diagnosed with the following high-risk conditions:

- [ICD-10 Code]: [Diagnosis Description]
- [ICD-10 Code]: [Diagnosis Description]

Due to the complexity of [Patient Name]'s medical history, which includes [Specific clinical details/complications], she requires a level of specialized care and multidisciplinary coordination that is not available within the current provider network. Specifically, [Out-of-Network Specialist Name] possesses unique expertise in [Specific procedure or management of specific condition] that is essential for a safe pregnancy outcome.

I have reviewed the list of in-network providers and determined that they do not have the specific clinical experience or the necessary facilities to manage this high-risk case safely. Delaying care or utilizing a less specialized provider would significantly increase the risk of maternal and fetal morbidity or mortality.

I request that you grant an administrative gap exception for [Patient Name] to receive all obstetric and specialty care from [Out-of-Network Specialist Name] for the duration of this pregnancy and the immediate postpartum period.

Thank you for your prompt attention to this urgent medical matter. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Referring Physician Signature]
[Referring Physician Printed Name]

[Medical License Number / NPI]
[Clinic/Hospital Name]