

[Date]

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

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

**Patient Name:** [Patient Full Name]  
**Policy Number:** [Policy Number]  
**Group Number:** [Group Number]  
**Date of Birth:** [MM/DD/YYYY]

To Whom It May Concern,

I am writing to formally request an out-of-network referral and a network gap exception for [Patient Name] to see [Out-of-Network Specialist Name], a [Specialty Type] specialist. This request is based on the medical necessity of timely intervention and the lack of available in-network providers within a reasonable timeframe.

**Clinical Justification:**

The patient has been diagnosed with [Diagnosis/Condition]. Treatment is required to prevent [mention potential complications, e.g., permanent injury, worsening of symptoms, or loss of function].

**In-Network Deficiency:**

I have attempted to schedule an appointment with the following in-network providers, but encountered excessive wait times that exceed medically acceptable standards for this condition:

- [In-Network Provider 1]: Next available appointment [Date] ([Number] weeks/months wait).
- [In-Network Provider 2]: Next available appointment [Date] ([Number] weeks/months wait).

The current wait times for in-network care represent a failure of the network to provide adequate access to necessary medical services. Delaying treatment until an in-network slot becomes available poses a significant risk to the patient's health.

**Requested Action:**

Due to these circumstances, I request that [Out-of-Network Specialist Name] be authorized for treatment at the in-network benefit level. Please provide a written response regarding this authorization by [Date].

Thank you for your prompt attention to this urgent matter.

Sincerely,

[Referring Physician Name]

[NPI Number]

[Phone Number]

[Practice Name]