

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

RE: Letter of Medical Necessity for Continuation of Out-of-Network Care

Patient Name: [Patient First and Last Name]
Patient Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally request a gap exception and authorization for continued out-of-network coverage for [Patient Name] to receive ongoing treatment from [Specialist Name] at [Facility Name]. [Patient Name] has been under the care of this specialist since [Start Date] for the management of [Diagnosis/Medical Condition, include ICD-10 code].

Continuity of care with [Specialist Name] is medically necessary for the following reasons:

- **Clinical Complexity:** The patient's condition is rare and complex, requiring the specific expertise of [Specialist Name], who has a detailed longitudinal history of the patient's response to treatment.
- **Lack of In-Network Alternatives:** There are currently no in-network providers within a reasonable geographic distance who possess the necessary sub-specialty expertise to manage this specific case.
- **Risk of Disruption:** Transferring care to a new provider at this critical stage of treatment poses a significant risk of clinical regression, medical complications, or [Specific Risk].
- **Treatment Plan:** The current treatment plan involves [Brief description of procedure, therapy, or medication regime], which is uniquely managed by this provider.

Given the medical necessity and the potential for adverse health outcomes if care is interrupted, I request that [Insurance Company Name] cover these services at the in-network benefit level. I have attached [Relevant Medical Records/Journal Articles/Clinical Notes] to support this request.

Please contact my office at [Phone Number] if you require further clinical documentation or have questions regarding this request. Thank you for your immediate attention to this matter.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO/Specialty]
[NPI Number]

[Practice Name]
[Phone Number]