Date: [Date]

To: [Insurance Company Name]
Attn: Utilization Management/Prior Authorization Department
Address: [Insurance Company Address]
Fax Number: [Fax Number, if applicable]

RE: Prior Authorization Request for Genetic Testing

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Member ID Number: [Insurance Member ID]
Group Number: [Group Number]
Case Reference Number: [Reference Number, if applicable]

Dear Prior Authorization Department,

I am writing to request prior authorization for genetic testing for the above-referenced patient. I have determined that this testing is medically necessary to guide the clinical management and treatment plan for this individual.

Requested Test(s): [Name of Genetic Test, e.g., Whole Exome Sequencing]
CPT Code(s): [Provide specific CPT codes]
Laboratory Name: [Name of Performing Laboratory]

Clinical Diagnosis and History:
The patient presents with [List symptoms, clinical findings, or ICD-10 codes]. Based on the patient's [personal/family] history of [describe relevant history], genetic testing is required to [confirm a diagnosis / determine treatment eligibility / assess risk].

Medical Necessity:
The results of this genetic test will directly impact the patient's medical management by [explain how results will change treatment, e.g., initiating specific medication, avoiding unnecessary procedures, or increasing surveillance].

Attached please find supporting clinical documentation, including office visit notes and relevant family pedigree.

Thank you for your prompt review of this request. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
Physician Name: [Provider Name]

NPI Number: [NPI Number]
Practice Name: [Facility Name]