[Date]
[Insurance Company Name]
[Prior Authorization Department]
[Insurance Company Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Genetic Testing
Patient Name: [Patient First and Last Name]
Patient Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Case Reference Number: [Reference Number, if applicable]

Dear Medical Review Manager,

I am writing to request a prior authorization and to provide a formal letter of medical necessity for genetic testing for my patient, [Patient Name]. I have recommended the following test: [Name of Genetic Test/Panel] (CPT Code: [Insert CPT Code]).

Patient Clinical History:
[Patient Name] is a [Age]-year-old individual presenting with a clinical history of [List symptoms, age of onset, and duration]. The patient's physical exam findings include [List relevant physical findings].

Family History:
The patient's family history is significant for [List relevant family history of disease or genetic conditions].

Medical Necessity and Clinical Utility:
Based on the patient's presentation, this genetic test is medically necessary for the following reasons:

- To establish a definitive diagnosis for [Suspected Condition].
- To differentiate between [Condition A] and [Condition B], which have overlapping symptoms but different management protocols.
- To determine the most appropriate pharmacological treatment or surgical intervention.
- To avoid further invasive or costly diagnostic procedures (e.g., biopsies or repeated imaging).

Treatment Plan:
The results of this test will directly impact the patient's management plan by [Explain how results will change treatment, e.g., starting a specific medication, increasing screening frequency, or preventing comorbidities].

In summary, this genetic testing is the current standard of care for a patient with this clinical profile. I request that you approve this request for [Genetic Test Name].

Please contact my office at [Phone Number] if you require additional documentation or clinical notes.

Sincerely,

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