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

RE: Prior Authorization Request for Genetic Testing

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Request Number/Reference: [If applicable]

To Whom It May Concern,

I am writing to request prior authorization for **[Name of Genetic Test]** (CPT Code: [Insert Code]) for the patient listed above. This test is being ordered at **[Laboratory Name]**.

Clinical Documentation:

The patient presents with a clinical diagnosis/suspected diagnosis of [Diagnosis/ICD-10 Code]. The patient's medical history includes: [Briefly list symptoms, age of onset, or relevant physical findings].

Family History:

[Describe relevant family history of the condition or related genetic markers].

Medical Necessity:

Genetic testing is medically necessary for this patient because the results will directly impact the clinical management in the following ways:

- [Confirming a definitive diagnosis]
- [Guiding specific pharmacological or surgical treatment options]
- [Determining the frequency of necessary screenings/surveillance]
- [Informing family members of potential risks]

Alternative diagnostic methods have been considered, but genetic testing is the most appropriate and cost-effective next step to avoid unnecessary future procedures or ineffective treatments.

Enclosed are the relevant clinical notes, family pedigree, and peer-reviewed literature supporting the use of this test for this indication. Please contact my office at [Phone Number] if you require further information.

Sincerely,

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