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

RE: Prior Authorization Request for Genetic Testing

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request prior authorization for [Name of Genetic Test] (CPT Code: [Insert Code]) for the above-mentioned patient. This test is medically necessary to [diagnose / determine treatment for] the patient's condition.

Clinical Diagnosis and History:
The patient presents with [List symptoms or diagnosis]. Their family history includes [List relevant family medical history]. To date, the following treatments or tests have been performed: [List previous tests/results].

Medical Necessity:
The requested genetic test is essential because [Explain how the results will change clinical management, such as starting a specific medication, avoiding unnecessary surgery, or screening for related conditions].

Requested Lab Information:
Laboratory Name: [Lab Name]
CLIA Number: [Number]
Phone: [Phone Number]

Attached you will find clinical notes, a pedigree chart, and the laboratory's test specifications to support this request. If you require further information, please contact my office at [Phone Number].

Sincerely,

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