Date: [Date]

To: [Insurance Company Name]
Attn: Prior Authorization Department
Fax/Address: [Fax Number or Mailing Address]

RE: Request for Prior Authorization for Genetic Testing

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

Dear Medical Review Department,

I am writing to request prior authorization for clinical genetic testing for the patient listed above. I have determined that this testing is medically necessary to guide the diagnosis and clinical management of the patient's condition.

Requested Test: [Name of Genetic Test/Panel]
CPT Code(s): [List CPT Codes]
Laboratory Name: [Name of Laboratory]

Clinical Indications:
The patient presents with the following signs, symptoms, or family history:
[Briefly describe clinical symptoms or relevant family history]

ICD-10 Diagnosis Code(s): [List Diagnosis Codes]

Medical Necessity:
The results of this genetic test will directly impact the patient's treatment plan in the following ways:
[Example: Confirming a suspected diagnosis, determining eligibility for specific medications, or directing surgical decisions.]

Included with this letter are the patient's clinical notes, relevant family history, and the laboratory's test description. Please contact my office at [Phone Number] if you require additional information to process this request.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]
[Practice Name/Address]