[Date]

[Health Plan 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: [CPT Code]) for the above-referenced patient. This testing is being ordered by [Ordering Physician Name] at [Facility Name].

Clinical Justification:
The patient presents with the following clinical indications and/or family history:

- [List relevant symptoms or diagnosis]
- [List relevant family history]
- [List previous failed treatments or non-diagnostic test results]

Medical Necessity:
The results of this genetic test are medically necessary because they will directly impact the patient's clinical management by:

- [Confirming or ruling out a suspected diagnosis]
- [Determining eligibility for targeted therapy]
- [Guiding surgical decisions or preventative screenings]
- [Avoiding unnecessary future diagnostic procedures]

Included with this letter are the patient's clinical notes, relevant family pedigree, and the laboratory's test description. We request a timely review of this request to ensure the patient receives appropriate care.

Should you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[NPI Number]
[Phone/Fax Number]