[Your Name]
[Your Title/Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Fax Number]

[Date]

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

RE: Prior Authorization Request for Genetic Testing

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case/Reference Number: [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 above-referenced patient. This testing is scheduled to be performed at **[Laboratory Name]**.

Clinical Justification:
The patient presents with a clinical diagnosis/suspicion of **[Diagnosis or Symptoms]** (ICD-10 Code: **[Insert Code]**). My clinical assessment and the patient's family history of **[Briefly mention relevant history]** indicate a high risk for **[Name of Genetic Condition]**.

Medical Necessity:
This genetic test is medically necessary to:

- Confirm a suspected diagnosis.
- Guide immediate treatment decisions and surgical interventions.
- Direct future preventative screenings and medical management.
- Identify risk factors for family members.

Standard clinical evaluations and alternative diagnostic methods have been considered, but genetic testing remains the most definitive tool for establishing a precise management plan for this patient.

Enclosed please find the following supporting documentation:

- Clinical office notes
- Relevant family pedigree/history
- Laboratory test results/previous imaging
- Letter of Medical Necessity from the specialist

Please contact my office at [Phone Number] if you require additional information to process this request. Thank you for your prompt attention to this matter.

Sincerely,

[Physician Signature]

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