Date: [Date]

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

RE: Prior Authorization Request for Genetic Testing

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case Reference Number: [Reference Number, if applicable]

Dear Medical Review Manager,

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 performed by **[Laboratory Name]**.

Clinical Justification:
The patient presents with the following clinical indications and/or family history:
[Insert Brief Clinical Summary, e.g., symptoms, age of onset, specific family members affected].

Medical Necessity:
This patient has been diagnosed with or is at high risk for **[Diagnosis Name]** (ICD-10 Code: **[ICD-10 Code]**). Standard diagnostic tools have been inconclusive, and this genetic test is necessary to:

- Confirm a suspected clinical diagnosis.
- Inform immediate pharmacological or surgical treatment decisions.
- Identify specific gene mutations to determine eligibility for targeted therapies.
- Direct future screening and preventative care protocols.

The results of this test will significantly impact the patient's clinical management and prevent the use of ineffective or unnecessary medical interventions.

Enclosed Documentation:
- Clinical notes and physical exam findings
- Relevant family pedigree/history
- Laboratory test requisition form
- Peer-reviewed literature supporting the use of this test for this condition

Please contact our office at [Phone Number] or via fax at [Fax Number] if you require additional information to process this request.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]
[Clinic Name]