[Date]

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

RE: Prior Authorization Request for Hereditary Risk Genetic Testing

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

To Whom It May Concern,

I am writing to request prior authorization for [Name of Genetic Test, e.g., BRCA1/2, Lynch Syndrome Panel] for the above-mentioned patient. This testing is medically necessary based on the patient's personal and/or family clinical history of [Specific Condition/Cancer].

Clinical Justification:
The patient meets the criteria for genetic testing due to the following:

- [Detail personal history of cancer/disease, including age of onset]
- [Detail family history of cancer/disease, including degree of relationship and age of onset]
- [List any previous relevant test results]

Medical Necessity:
The results of this genetic test will directly impact the patient's clinical management by:

- Guiding surgical decisions (e.g., prophylactic surgery).
- Determining the frequency and type of future diagnostic screenings.
- Informing pharmacological treatment options.

Requested Test Details:
Test Name: [Test Name]
Laboratory Name: [Laboratory Name]
CPT Code(s): [Insert CPT Codes, e.g., 81162, 81432]
ICD-10 Code(s): [Insert Diagnosis Codes]

Included with this letter are relevant clinical notes and a family pedigree for your review. Please contact my office at [Phone Number] if you require additional information.

Sincerely,

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