Date: [Date]

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

RE: Request for Prior Authorization for Targeted Genetic Testing

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

Dear Medical Reviewer,

I am writing to request prior authorization for targeted genetic testing for the above-referenced patient. I have determined that this specific genetic test is medically necessary to guide the clinical management and treatment plan for this patient.

Requested Test: [Specific Name of Genetic Test/Panel]
CPT Code(s): [Insert CPT Codes, e.g., 81211]
Laboratory: [Name of Performing Laboratory]

Clinical Justification:

- **Diagnosis:** [Primary Diagnosis and ICD-10 Code]
- **Clinical History:** [Briefly describe symptoms, age of onset, and relevant physical findings]
- **Family History:** [Note if there is a known familial mutation or relevant family history of the condition]
- **Prior Testing:** [List any previous diagnostic tests or imaging results that justify genetic testing]

Medical Necessity and Clinical Utility:
The results of this targeted genetic test will directly impact the patient's care by:
- [e.g., Confirming a suspected diagnosis]
- [e.g., Directing targeted pharmacological therapy]
- [e.g., Avoiding unnecessary future diagnostic procedures]
- [e.g., Informing surgical decision-making]

Attached please find supporting clinical documentation, including clinic notes and relevant lab reports. Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Name, MD/DO]
[NPI Number]
[Practice/Facility Name]
[Phone Number]