Date: [Date]

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

RE: Prior Authorization Request for Comprehensive Genetic Panel

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

To Whom It May Concern,

I am writing to request prior authorization for a **[Name of Specific Genetic Panel, e.g., Comprehensive Hereditary Cancer Panel]** (CPT Code: [Insert CPT Code(s)]) for the above-referenced patient. This testing is medically necessary to guide clinical management and treatment decisions.

Clinical Indication:
The patient presents with [List primary diagnosis/symptoms]. The patient's personal and/or family history includes:

- [History Detail 1]
- [History Detail 2]
- [History Detail 3]

Medical Necessity:
A comprehensive panel is required rather than single-gene testing because [Reason: e.g., overlapping clinical phenotypes, heterogeneous genetic causes, or cost-effectiveness]. The results of this test will directly impact the patient's care by:

- [Example: Identifying targeted therapy options]
- [Example: Determining the frequency of future screenings]
- [Example: Informing surgical decision-making]

Requested Laboratory:
Laboratory Name: [Lab Name]
Lab NPI: [Lab NPI]

Attached please find clinical notes, a detailed family pedigree, and relevant pathology reports supporting this request. If you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Name, MD/DO]
[Practice/Hospital Name]
[Phone Number]