DATE

**RE: PATIENT NAME   
DOB: MM/DD/YYYY**

MRN: ####

Subscriber ID: ####

Group Number: ####

To Whom It May Concern,

PATIENTNAME (DOB: MM/DD/YYYY) is <a/n> AGE year-old SEX who was evaluated by Dr. MDNAME <and GCNAME, MS, CGC> in the CLINIC Clinic on DATE OF VISIT. PATIENT NAME has a relevant clinical history of BRIEF CLINICAL HISTORY <IF RELEVANT: and a family history of FAMILYHISTORY>. This combination of clinical symptoms <and family history> <is/are> highly suggestive of an underlying genetic condition.

PATIENT NAME has had PREVIOUS TESTING which <has/have> not determined a cause for <his/her/their> clinical symptoms. At this time, Dr. MDNAME <and Ms/r. GCNAME> <is/are> recommending TESTNAME at LABNAME for PATIENTNAME.

[INSERT TEST-SPECIFIC EVIDENCE TO SUPPORT REQUEST FOR TESTING **BASED ON THE DENIAL REASON**]:

* If denied as “**not medically necessary**”:

Your notification letter states COMPANY policy #POLICY (LINK) was used in the review of our preauthorization request. The policy specifies <COPY/PASTE SPECIFIC POLICY CRITERIA OR WORDING (IF PROVIDED)>. *Explain why your patient meets the payer criteria. If the clinical history does not meet criteria according to the health plan’s policies, clarify why you believe an exception should be made for this patient. Alternatively, explain why the test is medically necessary for this patient and how the results can be used to better guide and improve their care. Focus on your patient’s specific situation. Generally, insurance payers want to know how testing will affect the patient, not about the technical validity of the test.*

* If denied as “**investigational/experimental**”:

Your notification letter states COMPANY policy #POLICY (LINK) was used in the review of our preauthorization request. The policy specifies that TESTNAME is investigational for PATIENTNAME. <REITERATE OR MODIFY MEDICAL NECESSITY RATIONALE FROM YOUR CLINIC NOTE>. We respectfully request an exception to your policy for PATIENTNAME. TESTNAME is a powerful diagnostic tool and is not investigational. The results of this genetic test will impact PATIENTNAME’s medical management.

Genetic testing is medically necessary for PATIENTNAME to determine the molecular etiology of <his/her/their> symptoms. <INCLUDE SPECIFIC GENOTYPE/PHENOTYPE INFO ABOUT SPECIFIC RESULTS AND IMPACT ON CARE>. Without the results of this genetic test, we will be unable to provide anticipatory guidance and screening recommendations (<I.E., IS THERE A DIFFERENCE IN RESPONSE TO MEDICATIONS, WOULD ADDITIONAL TESTS/PROCEDURES BE RECOMMENDED, OR WILL ADDITIONAL REFERRAL/SPECIALTY FOLLOW UP BE RECOMMENDED?>). In the absence of genetic testing, we would recommend a cautious approach to include increased screening for COMPLICATIONS without a POSITIVE/NEGATVIE result.

We are requesting preauthorization at your earliest opportunity. We strongly recommend TESTNAME for PATIENTNAME and hope you will consider this information when determining coverage for <him/her/them>. Please contact me directly at DEPARTMENT PHONE# should you have any additional questions or concerns. A preauthorization letter may be faxed to us at 206-985-3297.

Sincerely,

<PROVIDER NAME>

<PROVIDER SPECIALTY>

<GC/ADDITIONAL PROVIDER NAME>

<ADDITIONAL PROVIDER SPECIALTY>