<Physician Name>, MD

<Address 1>

<Address 2>

<City>, <State>

<ZIP>

<Today's Date>

<Insurance Company Name>

<AAddress 1>

ATTN: Pre-Authorization Department

Re: <Patient Full Name> DOB: <MM/DD/YYYY>

Member ID: <Enter Member ID> Group ID: <Enter Group ID>

Dear Sir or Madam:

I am writing this letter on behalf of my patient <Patient Name> to request coverage for the <Test Name>. This letter documents the medical necessity for this test to confirm the diagnosis of <Disease Name> and provides information about the patient’s medical history and treatment.

**Patient History and Diagnosis:**

<Patient Name> is a <Age> year old <Gender > with a suspected diagnosis of
<Disease Name> due to the following symptoms and clinical findings.

1. <Symptom #1>

2. <Symptom #2>

**Family History**

<Include relevant family history information if applicable >

This <<medical and/or family history>> confirms the necessity of molecular testing in making a definitive diagnosis. An accurate diagnosis is crucial for appropriate medical management.

Molecular testing plays an important role in making a definitive diagnosis in cases of suspected <Disease Name> to treat the patient appropriately. An accurate diagnosis provides the following benefits to the patient:

* <Benefit 1>

* <Benefit 2>

* <Benefit 3>

I am requesting that <Patient Name> be approved for <Test Name> testing through Molecular Vision Laboratory, Federal Tax ID #: 81-2685042/

NPI #: 1750739041 with the following CPT code(s): <CPT Codes>.

I hope you will support this letter of medical necessity for <Patient Name>. Please feel free to contact me at <Physician Phone> if you have additional questions.

Sincerely,

<Physician Name>, MD

NPI #: <Physician NPI#>