**LETTER OF MEDICAL NECESSITY TEMPLATE**

**INDIVIDUAL GENE GENETIC TESTING**

Date: Date of service/claim

To: Utilization Review Department

 Insurance Company Name, Address, City, State

Re: Patient Name, DOB, ID #

ICD-10 Codes: Insert relevant codes

This letter is regarding my patient, and your subscriber, referenced above, to request full coverage of medically indicated genetic testing for the gene(s) discussed below, to be performed by Ambry Genetics Corporation.

While medical policies have been developed by payors for the most common hereditary cancer syndromes (such as hereditary breast/ovarian cancer and Lynch syndrome), numerous rarer syndromes exist for which specific payor policies have not been developed. However, broad payor testing guidelines generally recognize the validity of performing genetic testing for these rarer syndromes when there are national and/or professional society guidelines supporting the clinical validity and utility of the test.

Significant aspects of my patient’s personal and/or family medical history that **suggest a reasonable probability of hereditary cancer are:** Insert clinical history.

Based on these factors, this testing is medically necessary, and we request that you approve coverage of genetic testing for this patient for the following gene(s): Insert genes.

This genetic testing can help determine an unaffected patient’s risk to develop cancer and could directly impact medical management. This testing may also impact the surgical and/or medical options available to treat an affected patient’s current cancer and can help determine their risk to develop other cancers in the future.

Thank you for your time, and please don’t hesitate to contact me with any questions.

Sincerely,

Ordering Clinician

**Test Details**

CPT codes: Insert CPT codes from test order.

Laboratory: Ambry Genetics Corporation (TIN 33-0892453 / NPI 1861568784), a CAP-accredited and CLIA-certified laboratory located at 7 Argonaut, Aliso Viejo, CA 92656