**LETTER OF MEDICAL NECESSITY TEMPLATE**

**SPECIFIC MUTATION 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 ICD 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.

Cancer is thought to have a hereditary component in up to 10% of cases. Mutations in multiple genes cause hereditary cancer syndromes, which markedly increase the lifetime risk for many types of cancer. While medical policies vary on the personal and/or family history needed to qualify for testing for individual genes and syndromes, it is universally recognized that there is clinical utility in testing blood relatives for a specific gene mutation once it has been identified in a family.

**This patient’s family has a known mutation in the** **{genes} gene,** and thus germline genetic testing is clinically indicated.

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.

Based on these factors, this testing is medically necessary, and we request that you approve coverage of genetic testing for this patient.

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

Sincerely,

Ambry Prior Authorization Department

**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