Letter of Medical Necessity

DATE:

PATIENT NAME:

PATIENT DOB (MM/DD/YYYY):

INSURANCE COMPANY NAME:

SUBSCRIBER NAME:

POLICY #:

GROUP #:

Dear Medical Director,

I am writing this letter on behalf of my patient and your subscriber to request full coverage for genetic testing performed by Invitae Corporation, a CAP-accredited and CLIA-certified clinical diagnostic laboratory located at 1400 16th Street, San Francisco, CA 94103.

IN ADDITION TO THE INFORMATION ON SUBMITTED ORDER FORMS, MY PATIENT HAS THE FOLLOWING SYMPTOMS, CLINICAL FINDINGS, AND/OR FAMILY HISTORY:

Knowledge of the patient's genetic information is important for me to more accurately assess my patient's condition and will guide my recommendations for care. Results from Invitae's genetic test will have a direct impact on my patient's treatment and management.

I am specifying the Invitae genetic test because it is a highly sensitive, cost effective, and clinically relevant.

Thank you for your review and consideration. I hope you will support this request for genetic testing coverage for my patient. If you have questions, or if I can be of further assistance, please do not hesitate to contact me.

Sincerely,

PHYSICIAN NAME:

PHONE: