[Today’s Date]

[Insurance Company Name]

[Address 1]

[City, State ZIP

Patient Name: [Patient Full Name] DOB: [MM/DD/YYYY]

Policy Number: [Policy Number]

Group ID: [Group Number]

Diagnosis: [Diagnosis]

Dear Insurance Team:

I am writing on behalf of my patient, [Patient Name], to request prior authorization and appropriate payment for Telomere Length Measurement, genetic testing. The patient is being evaluated for Dyskeratosis Congenita, a bone marrow failure syndrome, due to [his/her personal history of X and/or family history of X].

Telomere length analysis in these circumstances is standard of care and is medically indicated for the reasons listed below. This testing is neither experimental nor investigational as it will directly impact the patient’s medical care.

Personal Medical History: [Include details of patient’s relevant medical history]

Family History: [Include relevant family history information if applicable]

This [medical and/or family history] confirms the necessity of telomere length testing in making a definitive diagnosis. An accurate diagnosis is critical for appropriate medical management for reasons as follows.

A diagnosis of Dyskeratosis Congenita may be suspected based upon a thorough clinical evaluation, detailed patient history, and identification of characteristic findings that may include changes in the skin, nails or mouth. Very short telomeres in peripheral blood cells supports the diagnosis of Dyskeratosis Congenita in patients who present with bone marrow failure. A definitive Dyskeratosis Congenita diagnosis guides therapy selection and the choice for optimal protocols for treatment of bone marrow failure in this condition.

The cost of the Telomere Length test is $800.00 and will be performed under the CPT codes 88184 and 88185X3. The ICD-9-CM code(s) associated with this diagnosis is 757.39. The ordering physician is [Doctor’s Name], NPI#: [NPI#].

The laboratory providing the genetic testing is Repeat Diagnostics Inc. (CLIA # 99D1068060). Repeat Diagnostics is committed to providing comprehensive, high quality, and affordable genetic testing that adds value to patient care.

I am hopeful that we can work together for [Patient Name]’s benefit. Please contact me at [Phone #] with the result of this prior authorization and if you need additional information.

Sincerely,

[Name, Credentials]

[Title]

[Institution]