CIRCULOGENE

Client Services: 855-380-1555 Fax: 855-614-7084
3125 Independence Drive, Suite 301
Birmingham, AL 35209
support@circulogene.com

LETTER OF MEDICAL NECESSITY

DATE _____ PATIENT NAME _____ PATIENT DOB ___/___/___

INSURANCE COMPANY _____ SUBSCRIBER NAME _____

POLICY NUMBER _____ GROUP NUMBER _____

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 CIRCULOGENE, a CLIA-certified clinical diagnostic laboratory located at 3125 Independence Drive, Suite 301, Birmingham, AL 35209.

IN ADDITION TO THE INFORMATION ON SUBMITTED ORDER FORMS, I HAVE DETERMINED THIS TEST IS MEDICALLY NECESSARY FOR MY PATIENT DUE TO THE FOLLOWING RELEVANT SYMPTOMS, CLINICAL FINDINGS, AND/OR FAMILY HISTORY THAT ARE SUGGESTIVE OF A HEREDITARY, FAMILIAL OR SOMATIC CANCER SYMDROME IN MULTIPLE GENES:

Knowledge of this genetic information is important for the accurate assessment of the patient's condition, and results from CIRCULOGENE'S genetic panel test will have a direct impact on this patient's treatment and management.

I am specifying this CIRCULOGENE genetic panel because it is a highly sensitive, cost effective, and clinically relevant test. The patient has provided informed consent to pursue genetic testing.

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 NUMBER _____