# Letter of Medical Necessity

Patient's Name: _____

Patients Date of Birth: _____ Date: _____

To whom it may concern:

*Re: Medical Necessity for Laboratory Testing*

I am treating the above-named patient and certify that the following laboratory test(s) are medically necessary for the diagnosis, treatment or monitoring of a medical condition:

Test Name(s): _____

ICD-10 Code(s): _____

Date(s) of service: _____

Description of medical condition/clinical indication:

I further certify that this testing is not for general wellness only, but has a direct relationship to the diagnosis or treatment of the patient's condition.

Provider Name: _____

Provider Signature: _____

Provider NPI#: _____

Date: _____

Thank you.