To:
Medical Director
Insurer:

From:
Ordering Clinician:
NPI#:
Address:
City:
State: Zip:
Phone:

Regarding Patient:
Name:
DOB:
Insurance ID:
Subscriber ID:

Greetings;
I am writing to request that an exception be made to approve coverage of the tests performed by Ascenda BioSciences, for my patient listed above who has the following diagnoses relevant to this request:

Applicable ICD-10 Codes

Applicable CPT Codes (select all that apply)

- ☐ 87507 - GPX Panel
- ☐ 82784 - Anti-gliadin IgA
- ☐ 82656 - Elastase
- ☐ 82715 - Fecal Fat
- ☐ 82274 - Fecal Occ. Blood
- ☐ 87339 - H. pylori stool ant.
- ☐ 83993 - Calprotectin
- ☐ 83631 - Lactoferrin
- ☐ 87493 - C. Diff A & B
- ☐ 87339 - H. pylori Panel
- ☐ 87339 - Antibiotic Resistance Panel

In addition to a request for an exception for coverage, I am requesting that the test(s) be covered under the patient's IN-NETWORK benefits because Ascenda BioSciences is the sole provider of this test panel selection in the US. This test is medically necessary for the following reasons:_____

I believe my patient's symptoms _____
_____could be the result of a response to a bacterial, parasitic or viral infection. Ascenda BioSciences offers a group of tests known as the GPX, Proteins Panel, Antibiotic Resistance and Helicobacter pylori (H. pylori) which could provide me with laboratory evidence supporting a clinical diagnosis of the exact bacterial, parasitic or viral infection, IBS and IBD condition which requires a completely different course of treatment. Accurate and timely diagnosis using these panels will undoubtedly save the patient undue suffering and treatment delays as well as possible avoidable inpatient hospitalization.

An expedient diagnosis will result in faster and much more cost-effective treatment which will benefit both the patient and their insurance carrier. It will, or is reasonably expected to, prevent the worsening or continuation of an illness, condition, or disability. It will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, injury, or disability. It will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

Please let me know if you require additional information from my records.

Yours truly,

Signature:_____

Date:_____

Instructions - be specific and include this information:

- Cite past successes with the treatment
- Cite recent medical articles
- Include letters from consultants including physical or occupational therapists
- Review previous and failed treatments
- Address the HMO's suggested treatments
- Be specific about psychological factors that are relevant to your chosen treatment
- Provide information you have which a distant administrator may not know
- Cite conversations with family members or other treating physicians