[Date]
[Insurance Company Name]
[Attn: Medical Director / Appeals Department]
[Insurance Company Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Familial Hypercholesterolemia (FH) Genetic Testing
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Claim Number: [Claim Number (if applicable)]

To Whom It May Concern,

I am writing to request coverage for genetic testing for Familial Hypercholesterolemia (FH) for my patient, [Patient Name]. As their treating [Physician Title], I have determined that this testing is medically necessary to establish a definitive diagnosis and guide the clinical management of this patient's high-risk cardiovascular profile.

Clinical Indications:
The patient meets the clinical criteria for FH genetic screening based on the following:

- [Untreated LDL-C levels >190 mg/dL (adults) or >160 mg/dL (children)]
- [Personal history of early-onset coronary artery disease (Men <55, Women <65)]
- [Family history of premature cardiovascular disease or severe hypercholesterolemia]
- [Presence of physical exam findings: xanthomas or corneal arcus]
- [Dutch Lipid Clinic Network Score: Insert Score]

Medical Necessity:
FH is an autosomal dominant genetic disorder that significantly increases the risk of premature myocardial infarction and death. Genetic testing to identify mutations in the LDLR, APOB, or PCSK9 genes is the gold standard for diagnosis. Confirming a genetic diagnosis is essential for:

- Determining the intensity of lipid-lowering therapy (e.g., PCSK9 inhibitors).
- Initiating cascade screening for at-risk biological relatives.
- Informing prognosis and long-term risk stratification.

In summary, this testing is critical for the prevention of life-threatening cardiovascular events in this patient. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[NPI Number]
[Practice Name]