

Date: [Date]

To: [Insurance Company Name]

Attention: Medical Review/Prior Authorization Department

Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Continuous Glucose Monitor (CGM)

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Policy Number: [Policy ID]

Group Number: [Group ID]

To Whom It May Concern,

I am writing to request coverage for a Continuous Glucose Monitor (CGM) system for my patient, [Patient Name]. This patient has been diagnosed with Type 1 Diabetes Mellitus (ICD-10: E10.9) and is currently under my care.

Clinical Justification:

The patient requires intensive insulin therapy and must monitor their glucose levels frequently to prevent life-threatening complications. Despite current management, the patient continues to experience the following (check all that apply):

- Severe hypoglycemia (low blood sugar) with neuroglycopenic symptoms.
- Hypoglycemia unawareness (inability to detect dropping glucose levels).
- Frequent glycemic variability (significant highs and lows).
- Recurring ketoacidosis or hyperglycemia requiring intervention.
- Requirement for glucose testing 6 or more times per day.

Treatment Plan:

The use of a CGM is medically necessary for this patient to provide real-time data and alerts. This technology will allow for immediate adjustments to insulin dosing and lifestyle factors, reducing the risk of emergency room visits and long-term diabetic complications.

In my professional medical opinion, the CGM system is an essential component of this patient's diabetes management plan. Please approve this request for the necessary device and sensors.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/NP/PA]

[NPI Number]

[Practice Name]
[Phone Number]