Date: [Date]

To: [Insurance Company Name]
Attn: Appeals/Medical Review Department
Fax/Address: [Fax Number or Address]

Re: Letter of Medical Necessity for Continuous Glucose Monitoring (CGM)

Patient Name: [Patient 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) for my patient, [Patient Name].

Diagnosis: Type 2 Diabetes Mellitus, Insulin Dependent (ICD-10: E11.65 / E11.9)

Clinical Justification:
The patient has been diagnosed with insulin-dependent Type 2 diabetes and requires intensive insulin therapy. Current management includes:

- Treatment with [Number] daily injections of insulin or use of an insulin pump.
- Frequent blood glucose monitoring ([Number] times per day).
- Requirement for frequent insulin dosage adjustments based on glucose levels.

Medical Necessity:
Despite compliance with fingerstick monitoring, the patient continues to experience the following (check all that apply):

- [ ] Recurrent hypoglycemia (blood sugar
- [ ] Hypoglycemia unawareness
- [ ] Significant glycemic variability (wide swings in glucose levels)
- [ ] Suboptimal HbA1c levels of [Most Recent HbA1c]%

A CGM is medically necessary for this patient to prevent life-threatening hypoglycemic events, reduce emergency room visits, and achieve stable glycemic control. The real-time data and trend alerts provided by a CGM are essential for this patient's safety and effective management of their condition.

I request that you approve the request for the [Specific CGM Brand/Model] and associated supplies.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Phone Number]
[Clinic Name]