

Date: [Date]

To: [Insurance Company Name]

Attention: Prior Authorization Department / Medical Review Board

Fax/Address: [Fax Number or Address]

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

Patient Name: [Patient Name]

Date of Birth: [Patient DOB]

Member ID: [Insurance ID Number]

Group Number: [Group Number]

Provider Case Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to request coverage for a Continuous Glucose Monitor (CGM) system and related supplies for my patient, [Patient Name], who is currently under my care for **Gestational Diabetes Mellitus (ICD-10: O24.419)**.

Clinical Justification:

The patient is currently [Number] weeks pregnant. Tight glycemic control is critical in this pregnancy to prevent maternal and fetal complications, including macrosomia, preeclampsia, neonatal hypoglycemia, and stillbirth.

The patient meets the following criteria for medical necessity:

- The patient requires frequent blood glucose monitoring (more than 4-8 times per day) to manage insulin dosing or medication adjustments.
- The patient is experiencing significant glycemic variability or nocturnal hypoglycemia.
- Traditional finger-stick monitoring is insufficient to capture the rapid glucose fluctuations associated with gestational hormonal changes.
- Real-time alerts are necessary to prevent dangerous hypoglycemic episodes.

Requested Equipment:

[Specific Brand of CGM System, e.g., Dexcom G6/G7 or FreeStyle Libre 2/3] and associated sensors/transmitters.

In summary, a CGM is a vital medical tool for this patient to ensure a safe pregnancy and delivery. I ask that you approve this request for the duration of the pregnancy and the immediate postpartum period.

Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice Name]

[NPI Number]