Date: [Date]

To: [Insurance Company Name]
Attention: Medical Review/Appeals Department
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

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

To Whom It May Concern,

I am writing to formally request coverage for a Continuous Glucose Monitor (CGM) for my patient, [Patient Name], who has been diagnosed with [Type 1 / Type 2 insulin-dependent] Diabetes Mellitus (ICD-10 code: [Code]).

The patient currently suffers from **Hypoglycemia Unawareness**. Despite frequent manual blood glucose monitoring ([Number] times per day), the patient is unable to perceive the physiological symptoms of dropping blood sugar levels. This condition has resulted in:

- Recurrent episodes of severe hypoglycemia (blood glucose below 54 mg/dL).
- [Optional: Mention any emergency room visits or assistance required from others].
- Frequent nocturnal hypoglycemia that poses a significant risk of seizure or coma.

A CGM system is medically necessary for this patient because it provides real-time glucose readings and, most importantly, integrated "Low Glucose" alerts and predictive alarms. These features are critical to notify the patient of falling glucose levels before a life-threatening event occurs.

Standard finger-stick monitoring is insufficient for this patient as it only provides a single point-in-time reading and cannot alert the patient during sleep or when symptoms are absent.

I am prescribing the [Specific CGM Brand/Model] to improve glycemic control and prevent severe hypoglycemic emergencies. Please approve this request for the necessary device and sensors.

Sincerely,

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