

Date: [Date]

To: [Insurance Company Name]

Attention: Medical Review Department

Fax/Address: [Fax Number/Address]

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

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Policy Number: [Policy Number]

Dear Medical Reviewer,

I am writing to request coverage for a Continuous Glucose Monitor (CGM) and related supplies for the above-referenced patient. This patient has been diagnosed with [Type 1 / Type 2] Diabetes Mellitus (ICD-10 code: [Code]).

This patient meets Medicare criteria for a therapeutic CGM based on the following clinical indicators:

- The patient has a diagnosis of diabetes mellitus.
- The patient is currently treated with insulin [Number] or more times per day, or via a continuous subcutaneous insulin infusion (insulin pump).
- The patient's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of therapeutic CGM testing results.
- Within six months prior to ordering the CGM, the patient has had an in-person or telehealth visit with the treating practitioner to evaluate their diabetes control.
- The patient/caregiver has received training on the use of the device and has demonstrated the ability to use the CGM as documented in the medical record.

Clinical Justification:

Despite adhering to a prescribed diabetes management plan, the patient continues to experience [mention specific issues: e.g., hypoglycemia unawareness, frequent nocturnal hypoglycemia, or severe glycemic variability]. The use of a CGM is medically necessary to provide real-time glucose data, trend information, and alerts to prevent life-threatening hypoglycemic events and improve overall glycemic control.

I am prescribing the [Brand Name of CGM System]. Please contact my office at [Phone Number] if further documentation is required.

Sincerely,

[Physician Signature]

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

[NPI Number]
[Practice Name]