[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

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

RE: Letter of Medical Necessity for Equipment Upgrade

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Diagnosis: [e.g., Type 1 Diabetes Mellitus (E10.9)]

To Whom It May Concern,

I am writing to request a medical equipment upgrade for my patient, [Patient Name], from their current Continuous Glucose Monitor (CGM) to the [Name of New CGM System].

The patient has been using the [Current CGM System] since [Date]. However, an upgrade is now medically necessary for the following reasons:

- **Device Age:** The current device has reached the end of its useful lifespan and is no longer under warranty.
- **Clinical Necessity:** The patient requires the updated features of the [New System], including [e.g., improved accuracy, predictive alerts for hypoglycemia, integration with insulin pump, or no fingerstick calibrations].
- **Medical History:** The patient continues to experience [e.g., hypoglycemic unawareness, frequent nocturnal glucose fluctuations, or high A1c levels] which necessitate the most advanced monitoring technology available.

Upgrading to this system is essential to prevent severe complications, including emergency room visits or hospitalizations related to glycemic instability. The [New System] is the most appropriate treatment to manage this patient's condition effectively.

I request that you approve the coverage for this upgraded CGM system immediately. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[NPI Number]