Date: [Date]

To: [Insurance Company Name]
Attention: Medical Review/Prior Authorization Department
Fax/Address: [Fax Number or Address]

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

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Member ID]
Group Number: [Group ID]

To Whom It May Concern,

I am writing to request coverage for a Continuous Glucose Monitor (CGM) system for the above-named patient. The patient has been diagnosed with [Type 1 / Type 2] Diabetes Mellitus (ICD-10: [Code, e.g., E11.9]).

Despite adherence to a prescribed insulin regimen and frequent manual Blood Glucose Monitoring (BGM), the patient continues to exhibit uncontrolled Hemoglobin A1C levels. The patient's most recent A1C was [Insert A1C %] on [Date].

Clinical Justification:

- The patient requires [Number] or more insulin injections per day or uses an insulin pump.
- The patient performs manual finger-stick testing [Number] times per day, yet glucose fluctuations remain significant.
- The patient experiences [frequent hypoglycemia / hypoglycemia unawareness / nocturnal hypoglycemia / significant glycemic variability].
- Current treatment adjustments based on BGM have failed to bring the A1C within the target range of [Target %].

A CGM is medically necessary for this patient to provide real-time glucose data, trend patterns, and alerts for glucose excursions. This technology is vital to prevent long-term diabetic complications and emergency room visits due to acute glycemic events.

I request that you approve the request for the [Specific CGM Brand/Model] and all necessary sensors and transmitters.

Sincerely,

[Physician Signature]
Physician Name: [Provider Name]
NPI Number: [NPI Number]
Phone Number: [Phone Number]