

**Date:** [Date]

**To:** [Insurance Company Name]

**Attn:** Medical Review/Appeals Department

**Fax/Address:** [Fax Number or Address]

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Policy Number:** [Policy ID]

**Group Number:** [Group Number]

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

To Whom It May Concern,

I am writing to request the continued coverage of a Continuous Glucose Monitor (CGM) system for my patient, [Patient Name]. [Patient Name] has been diagnosed with [Type 1 / Type 2 Insulin-Requiring] Diabetes Mellitus (ICD-10: [Code]) and has been utilizing a CGM system since [Start Date].

The patient requires a CGM for the ongoing management of their condition due to the following medical reasons:

- The patient requires intensive insulin therapy, involving [Number] or more injections per day or the use of an insulin pump.
- The patient performs frequent blood glucose monitoring (at least 4 times per day).
- The patient has a history of [Hypoglycemia unawareness / Severe hypoglycemic events / Significant glycemic variability].
- Current clinical data shows that the use of CGM has resulted in [Improved HbA1c levels / Reduction in emergency department visits / Decreased hypoglycemic episodes].

Discontinuation of this device would pose a significant health risk, including the potential for life-threatening hypoglycemic events and long-term diabetic complications. The CGM is an integral part of the patient's treatment plan to maintain glycemic control.

Based on the patient's successful adherence to the technology and the demonstrated clinical benefit, I request that you approve the continuation of care and coverage for the [Specific Brand/Model] CGM system and associated supplies.

Please contact my office at [Phone Number] if you require additional medical records or documentation.

Sincerely,

[Physician Signature]

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

[NPI Number]

[Practice Name]