Date: [Date]

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

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

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

To Whom It May Concern,

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

The medical necessity for this device is primarily due to the patient's significantly impaired manual dexterity caused by [Condition, e.g., Severe Peripheral Neuropathy, Rheumatoid Arthritis, Parkinson's Disease, or Post-Stroke Paralysis].

Due to this impairment, the patient experiences the following clinical challenges:

- Inability to perform frequent finger-stick blood glucose testing independently.
- Difficulty manipulating small test strips and lancing devices.
- High risk of hypoglycemia unawareness and severe glycemic variability.
- Reliance on a caregiver for routine testing, which is not feasible for the required [Number] times per day.

A CGM system is medically necessary to provide real-time glucose data and automated alerts without the requirement of frequent manual manipulation of testing supplies. This technology is essential to prevent emergency department visits and life-threatening hypoglycemic events.

I am prescribing the [Specific CGM Brand/Model] system. This device is an integral part of this patient's diabetes treatment plan to ensure safety and glycemic control.

Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

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