

Date: [Date]

To: [Insurance Company Name]

Attention: [Prior Authorization/Appeals Department]

Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Weight Loss Intervention

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Policy Number: [Policy Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for a weight loss intervention for my patient, [Patient Name], who has been diagnosed with moderate-to-severe Obstructive Sleep Apnea (OSA) (ICD-10 code: G47.33).

The patient currently presents with a Body Mass Index (BMI) of [Patient BMI]. Clinical evidence strongly indicates that the patient's excess weight is a primary contributing factor to the narrowing of the upper airway, resulting in significant nocturnal desaturations and disrupted sleep patterns. Currently, the patient's Apnea-Hypopnea Index (AHI) is [Insert AHI Number].

Weight reduction is medically necessary for this patient to achieve the following clinical goals:

- Reduction of the Apnea-Hypopnea Index (AHI).
- Improvement of oxygen saturation levels during sleep.
- Reduction of cardiovascular risks associated with OSA, such as hypertension and heart failure.
- Improvement of compliance with or potential titration off CPAP/BiPAP therapy.

I am prescribing [Specific Program/Medication/Treatment Name] as a critical component of the patient's treatment plan for OSA. Traditional conservative measures have been [discussed/attempted] without adequate resolution of the underlying sleep disorder.

In summary, this intervention is not elective or cosmetic; it is a vital medical necessity to treat a diagnosed respiratory condition and prevent further long-term health complications. I urge you to approve this request for [Patient Name].

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]