Date: [Date]

TO: [Insurance Company Name]
ATTN: [Department/Appeals]
FAX: [Fax Number]

RE: Letter of Medical Necessity for CPAP Therapy
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request coverage for a Continuous Positive Airway Pressure (CPAP) device and related supplies for the above-referenced patient. I have diagnosed this patient with Obstructive Sleep Apnea (OSA) based on clinical evaluation and diagnostic testing.

Clinical Findings:

- **ICD-10 Diagnosis:** G47.33 (Obstructive Sleep Apnea)
- **Sleep Study Date:** [Date of Sleep Study]
- **Apnea-Hypopnea Index (AHI) or RDI:** [Value]
- **Oxygen Desaturation:** [Lowest SpO2 %]
- **Symptoms:** [e.g., Excessive daytime sleepiness, snoring, witnessed gasping, hypertension]

Treatment Plan:

The patient requires a CPAP machine (HCPCS E0601) set at a pressure of [Pressure Setting] cm H2O. To ensure compliance and effectiveness, the patient also requires the following supplies (HCPCS codes A7030-A7039):

- CPAP Mask (Interface)
- Headgear and Chin Strap
- Replacement Filters and Tubing
- Humidifier Water Chamber

Medical Justification:

CPAP therapy is the gold standard for treating OSA. Without this treatment, the patient is at significant risk for associated comorbidities, including cardiovascular disease, stroke, and debilitating daytime fatigue. This equipment is medically necessary to maintain the patient's airway patency during sleep.

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

Sincerely,

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