[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attn: Medical Review/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Replacement CPAP Equipment

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

To Whom It May Concern,

I am writing to formally request the replacement of Continuous Positive Airway Pressure (CPAP) equipment for my patient, [Patient Name], who has been diagnosed with Obstructive Sleep Apnea (Diagnosis Code: [ICD-10 Code]).

The patient has been successfully utilizing CPAP therapy since [Original Start Date]. However, the current device (Model: [Current Model Name]) now requires replacement due to the following reason(s):

- [Option 1: The current equipment is over five years old and has reached its five-year useful lifetime.]
- [Option 2: The current equipment is malfunctioning and beyond economical repair.]
- [Option 3: The current equipment was damaged/lost due to (Specify Reason).]

The patient continues to demonstrate high compliance with the therapy and experiences significant improvement in clinical symptoms when utilizing the device. Continued CPAP therapy is medically necessary to prevent complications associated with untreated sleep apnea, such as hypertension, cardiovascular disease, and excessive daytime somnolence.

I am prescribing the following replacement equipment:

- [New Device Model Name and HCPCS Code]
- [Humidifier Type]
- [Mask/Interface and replacement supplies]

Please approve the request for this replacement equipment to ensure the patient's treatment remains uninterrupted. If you require further documentation, please contact my office at [Phone Number].

Sincerely,

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