Date: [Date]

To: [Insurance Company Name]
Attn: Appeals/Medical Review Department
Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for CPAP Therapy
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 Continuous Positive Airway Pressure (CPAP) machine and associated supplies for the above-mentioned patient. This equipment is medically necessary to treat a diagnosis of Severe Obstructive Sleep Apnea (ICD-10 Code: G47.33).

Clinical Findings:
The patient underwent a diagnostic sleep study on [Date of Sleep Study]. The results confirmed a diagnosis of Severe OSA based on the following criteria:

- **Apnea-Hypopnea Index (AHI):** [Insert AHI, e.g., 35] events per hour.
- **Oxygen Desaturation:** Lowest SpO2 reached [Percentage]%.
- **Symptoms:** The patient presents with [list symptoms, e.g., excessive daytime somnolence, witnessed gasping/choking, and cardiovascular strain].

Treatment Plan:
Based on the severity of the patient's condition, CPAP therapy is the gold standard of care. Untreated severe OSA puts the patient at significant risk for hypertension, myocardial infarction, stroke, and cardiac arrhythmias. I have prescribed the following:

- [HCPCS Code E0601] Continuous Positive Airway Pressure (CPAP) Device
- [HCPCS Code] Appropriate Interface (Mask) and Heated Humidifier
- Related replacement supplies (Filters, Tubing, Water Chamber)

I am requesting that you approve the purchase or rental of this device immediately to ensure the patient's safety and long-term health. Please contact my office at [Phone Number] if you require further documentation or clinical notes.

Sincerely,

[Physician Signature]

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