Date: [Insert Date]

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

RE: Letter of Medical Necessity for Auto-Titrating Positive Airway Pressure (APAP)

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for an Auto-Titrating Continuous Positive Airway Pressure (APAP) device (HCPCS code E0601) and related supplies for the aforementioned patient.

Diagnosis:
The patient has been diagnosed with [Insert Diagnosis, e.g., Obstructive Sleep Apnea, G47.33] based on a clinical evaluation and a diagnostic sleep study performed on [Date of Study].

Clinical Justification:
A standard fixed-pressure CPAP is insufficient for this patient for the following reasons:

- [Reason 1: e.g., Patient requires varying pressure due to positional sleep apnea.]
- [Reason 2: e.g., Patient experienced intolerance to fixed pressure during titration.]
- [Reason 3: e.g., Fluctuations in weight or physiological state require breath-by-breath adjustment.]

Prescription:
I am prescribing an APAP device with the following settings:
- Pressure Range: [e.g., 5-15] cm H2O
- Features: [e.g., Integrated Heated Humidifier, Heated Tubing]
- Duration of Use: Lifetime/99 months

The use of this device is medically necessary to treat the patient's condition, prevent long-term cardiovascular complications, and improve daytime functionality. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

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

[NPI Number]
[Practice Name]