[Date]

[Insurance Provider Name]
[Prior Authorization Department]
[Provider Address]
[City, State, Zip Code]

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

To Whom It May Concern,

I am writing to formally request coverage for a Continuous Positive Airway Pressure (CPAP) device and related supplies for the above-mentioned pediatric patient. [Patient Name] is currently under my care for the treatment of Obstructive Sleep Apnea (OSA).

Clinical Diagnosis:

- ICD-10 Code: G47.33 (Obstructive Sleep Apnea, Pediatric)
- [List additional relevant diagnoses, e.g., Hypertrophy of Tonsils/Adenoids, Obesity, Craniofacial Abnormalities]

Clinical Findings and Medical History:

The patient underwent an attended Polysomnogram (Sleep Study) on [Date of Study]. The results indicated the following:

- Apnea-Hypopnea Index (AHI): [Insert AHI] events per hour
- Oxygen Desaturation Nadir: [Insert Percentage]%
- Clinical Symptoms: [e.g., Snoring, witnessed gasping, daytime somnolence, behavioral issues, or failure to thrive]

Treatment Plan:

Based on the severity of the patient's condition and the results of the sleep study, I have prescribed CPAP therapy at a pressure setting of [Insert Pressure, e.g., 6 cm H2O]. This intervention is medically necessary to maintain airway patency during sleep, prevent nocturnal hypoxemia, and mitigate long-term cardiovascular and developmental complications associated with untreated pediatric OSA.

Requested Equipment:

- E0601: CPAP Device with Integrated Heated Humidifier

- A7034: Nasal or Full Face Mask (Pediatric Sizing)
- A7035: Headgear
- A7037: Tubing
- A7038/A7039: Filters

I request that you approve the coverage for this essential medical equipment. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Specialty]
[NPI Number]
[Clinic/Hospital Name]