Date: [Insert Date]

RE: Letter of Medical Necessity for Portable CPAP Therapy

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Policy/ID Number: [Insert ID Number]

To Whom It May Concern,

I am writing to formally document the medical necessity of a portable Continuous Positive Airway Pressure (CPAP) device for my patient, [Patient Name].

The patient has been diagnosed with Obstructive Sleep Apnea (ICD-10 Code: G47.33). Clinical evaluation and diagnostic testing have confirmed that the patient requires nightly positive airway pressure therapy to maintain airway patency, prevent nocturnal hypoxemia, and mitigate the risk of cardiovascular complications associated with untreated sleep apnea.

The patient is currently compliant with a standard CPAP device; however, due to [frequent work travel / necessary lifestyle requirements], a portable CPAP unit is medically required. A portable device ensures:

- Uninterrupted treatment adherence while away from home.
- Compatibility with varying power sources (including battery backup for transit).
- Reduced physical strain and improved portability for a patient who must maintain therapy 365 days a year.

Discontinuation of CPAP therapy during travel poses a significant health risk, including excessive daytime somnolence and increased respiratory distress. Therefore, I am prescribing the following equipment:

Requested Equipment: [Insert Specific Model, e.g., Travel CPAP Machine]
HCPCS Code: E0601

Please expedite the approval of this essential medical equipment. If you require further clinical documentation, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

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