Date: [Date]

To: [Insurance Company Name]
Attention: [Claims/Authorization Department]
Fax/Address: [Fax Number or Mailing Address]

RE: Letter of Medical Necessity for Continued CPAP Therapy

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Insurance ID Number]
Group Number: [Group Number]
Diagnosis: Obstructive Sleep Apnea (ICD-10 Code: G47.33)

To Whom It May Concern,

I am writing to document the medical necessity for continued Continuous Positive Airway Pressure (CPAP) therapy and the ongoing replacement of necessary supplies (masks, filters, tubing, and water chambers) for the above-mentioned patient.

The patient was originally diagnosed with Obstructive Sleep Apnea (OSA) on [Date of Original Diagnosis] following a polysomnography study which showed an Apnea-Hypopnea Index (AHI) of [Insert AHI].

Since initiating CPAP therapy, the patient has demonstrated consistent compliance and clinical improvement. A recent review of the patient's device data from [Start Date] to [End Date] confirms:

- **Compliance:** [Percentage]% of nights used for >4 hours.
- **Average Daily Use:** [Number] hours.
- **Residual AHI:** [Number] events per hour with therapy.

The patient reports significant reduction in daytime somnolence and improved cognitive function. Discontinuation of this therapy or failure to maintain the equipment with fresh supplies would result in a recurrence of sleep apnea symptoms and increase the patient's risk for comorbid conditions such as hypertension, cardiovascular disease, and stroke.

Based on the patient's positive response and documented adherence, I am prescribing the continued use of CPAP therapy at a pressure of [Insert Pressure Setting] cmH2O. Please approve the ongoing coverage for the machine rental/purchase and all associated replacement supplies.

If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

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