[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Appeal of Coverage Denial for Continuous Positive Airway Pressure (CPAP) Therapy

Patient Name: [Patient Full Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Claim Number from Denial Letter]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for Continuous Positive Airway Pressure (CPAP) therapy, as outlined in your letter dated [Date of Denial Letter]. The reason for denial was stated as [Insert Reason Provided by Insurance].

I have been diagnosed with Obstructive Sleep Apnea (OSA), a serious medical condition, by my physician, [Doctor's Name]. Based on my clinical evaluation and the results of my sleep study (Polysomnography) conducted on [Date of Study], CPAP therapy is medically necessary for my health and safety.

My sleep study results indicated an Apnea-Hypopnea Index (AHI) of [Insert AHI Number], which confirms a diagnosis of [Mild/Moderate/Severe] sleep apnea. Untreated OSA puts me at significant risk for life-threatening complications, including hypertension, heart disease, and stroke. Furthermore, I experience [List Symptoms, e.g., excessive daytime sleepiness, cognitive impairment, or morning headaches], which severely impact my daily functioning.

According to the standard of care established by the American Academy of Sleep Medicine, CPAP is the primary and most effective treatment for OSA. Attached you will find the following supporting documentation:

- A Letter of Medical Necessity from my treating physician.
- Results from my diagnostic sleep study.
- Clinical notes detailing my symptoms and previous failed attempts at alternative treatments (if applicable).

I request that you reconsider your decision and approve coverage for the CPAP machine and necessary supplies (mask, tubing, filters) immediately. This treatment is not elective; it is a vital medical intervention required to manage a chronic disease.

I look forward to your prompt response regarding this appeal. Please contact me at [Phone Number] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name]