[Date]

[Insurance Company Name]
[Attn: Medical Review/Appeals Department]
[Insurance Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Biofeedback Therapy
Patient Name: [Patient Full 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 Biofeedback Therapy (CPT Code: [Insert Code, e.g., 90901 or 90875]) for my patient, [Patient Name], who is currently under my care for the treatment of Chronic Insomnia (ICD-10 Code: G47.00).

Clinical History and Diagnosis:
The patient has been suffering from chronic insomnia for [Number] months/years. Symptoms include prolonged sleep latency, frequent nocturnal awakenings, and significant daytime impairment. This condition has negatively impacted the patient's cognitive function, metabolic health, and overall quality of life.

Previous Treatments Attempted:
The following conservative treatments have been attempted with insufficient results:

- Sleep Hygiene Education: [Duration/Outcome]
- Pharmacological Intervention: [List Medications and side effects/failures]
- Cognitive Behavioral Therapy for Insomnia (CBT-I): [Duration/Outcome]

Rationale for Biofeedback Therapy:
Biofeedback is medically necessary for this patient to address physiological hyperarousal, a primary driver of their chronic insomnia. This therapy will provide the patient with real-time physiological data (such as heart rate variability and electromyography) to develop self-regulation skills necessary to reduce sympathetic nervous system activity and initiate sleep without total reliance on sedative-hypnotic medications.

Treatment Plan:
I am prescribing [Number] sessions of biofeedback therapy over a period of [Number] weeks. We expect to see a measurable reduction in sleep latency and an improvement in sleep efficiency as a result of this intervention.

Based on the patient's clinical presentation and the failure of conventional therapies, I request that you approve this request for Biofeedback Therapy. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

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