Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department
FAX: [Fax Number]
PHONE: [Phone Number]

RE: Initial Prior Authorization Request for CPAP Therapy
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Request Reference Number: [If applicable]

Dear Prior Authorization Department,

I am writing to request prior authorization for a Continuous Positive Airway Pressure (CPAP) machine and related supplies for the above-referenced patient. This equipment is medically necessary to treat the patient's diagnosed Obstructive Sleep Apnea (OSA).

Clinical Documentation:

- **Diagnosis:** Obstructive Sleep Apnea (ICD-10 Code: G47.33)
- **Sleep Study Date:** [Date of Polysomnography or Home Sleep Test]
- **Apnea-Hypopnea Index (AHI) / Respiratory Disturbance Index (RDI):** [Insert Value] events per hour
- **Oxygen Desaturation:** [Insert Lowest SpO2 % if applicable]
- **Symptoms:** [e.g., Excessive daytime sleepiness, snoring, witnessed gasping, hypertension]

Requested Equipment/Supplies:

- E0601: CPAP Device
- A7034: Nasal Interface (Mask)
- A7037: Tubing
- A7038/A7039: Filters
- E0562: Heated Humidifier

The patient has been evaluated, and CPAP therapy is the recommended primary treatment to mitigate the risks associated with untreated OSA, including cardiovascular disease and daytime cognitive impairment. Attached you will find the formal sleep study results and the physician's signed prescription.

Please contact my office at [Phone Number] if further information is required to process this request.

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]
[Phone Number]