Date: [Date]
To: [Insurance Company Name]
Attention: Utilization Management/Prior Authorization Department
Fax/Phone: [Fax Number / Phone Number]

RE: Prior Authorization Request for In-Lab Polysomnography (CPT 95810)

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]

Dear Medical Director,

I am writing to request prior authorization for an attended, in-lab polysomnography (PSG) for the above-referenced patient. Based on the patient's clinical presentation and medical history, this diagnostic study is medically necessary to evaluate for [Specific Diagnosis, e.g., Obstructive Sleep Apnea, Narcolepsy, Periodic Limb Movement Disorder].

Clinical Indications:

- **Symptoms:** [e.g., Excessive daytime sleepiness, witnessed gasping/apnea, refractory insomnia]
- **Physical Findings:** [e.g., BMI, Mallampati Score, Neck Circumference]
- **Comorbidities:** [e.g., Congestive heart failure, stroke, neuromuscular disease, or severe COPD]
- **Reason for In-Lab vs. Home Study:** [e.g., Patient has significant comorbidities, previous inconclusive HST, or suspicion of non-respiratory sleep disorder]

Requested Service:

- **Procedure Code:** CPT 95810 (Polysomnography; age 6 or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist)
- **ICD-10 Code:** [Insert Diagnosis Code, e.g., G47.33]
- **Facility Name:** [Name of Sleep Lab/Hospital]

Enclosed please find clinical notes and relevant medical records supporting this request. If you require additional information, please contact my office at [Phone Number].

Sincerely,

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