

Date: [Date]

To: [Insurance Company Name]

Attention: Prior Authorization Department

Fax/Address: [Fax Number or Address]

RE: Prior Authorization Request for Home Sleep Apnea Test (HSAT)

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Policy Number: [Policy ID]

Group Number: [Group Number]

Case Reference Number: [Reference Number, if applicable]

Dear Medical Review Department,

I am writing to request prior authorization for a Home Sleep Apnea Test (CPT Code: 95806 or G0399) for the above-mentioned patient. This test is medically necessary to evaluate the patient for Obstructive Sleep Apnea (OSA).

Clinical Justification:

The patient presents with the following symptoms and risk factors:

- [List symptom, e.g., Excessive daytime sleepiness (Epworth Score: XX)]
- [List symptom, e.g., Witnessed apneas or gasping during sleep]
- [List symptom, e.g., Loud habitual snoring]
- [List comorbid condition, e.g., Hypertension or BMI > 30]

Physical Examination Findings:

- [List finding, e.g., Mallampati Score: III/IV]
- [List finding, e.g., Increased neck circumference: XX inches]

Based on the clinical presentation, the patient meets the criteria for a diagnostic sleep study. A home-based study is requested as the initial diagnostic tool in accordance with standard clinical guidelines for patients without significant comorbidities (such as central sleep apnea or severe pulmonary disease) that would require an in-lab study.

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

Thank you for your prompt attention to this matter.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Phone Number]