PRIOR AUTHORIZATION REQUEST

Date: [Date]

TO: [Insurance Company Name]
Attn: Prior Authorization Department
Fax/Phone: [Fax Number/Phone Number]

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

Provider Information
Requesting Physician: [Physician Name]
NPI Number: [NPI Number]
Phone: [Phone Number]
Fax: [Fax Number]

Facility Information
Facility Name: [Sleep Lab/Clinic Name]
NPI Number: [Facility NPI]
Tax ID: [Facility Tax ID]

Requested Procedure: In-Lab CPAP Titration Sleep Study (CPT Code: 95811)
Diagnosis: Obstructive Sleep Apnea (ICD-10 Code: G47.33)

Clinical Justification:
The patient has been diagnosed with Obstructive Sleep Apnea (OSA) based on a prior diagnostic sleep study (Polysomnography or Home Sleep Test) performed on [Date of Initial Study]. Results showed an AHI of [Insert AHI].

The patient requires an in-lab CPAP titration for the following reason(s):
[ ] Initiation of CPAP therapy to determine optimal pressure settings.
[ ] Significant recurrence of symptoms despite current therapy.
[ ] Underlying comorbidities (e.g., COPD, CHF, or Neuromuscular disease) requiring supervised titration.
[ ] Failure of auto-adjusting PAP (APAP) to control symptoms.

Supporting clinical notes and the initial diagnostic report are attached for your review.

Please provide an authorization number or contact our office if further information is required.

Sincerely,

[Physician Signature]
[Physician Printed Name]