

**DATE:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** Prior Authorization Department

**FAX:** [Fax Number]

**RE: PRIOR AUTHORIZATION REQUEST FOR PEDIATRIC SLEEP STUDY (PSG)**

**PATIENT INFORMATION:**

**Name:** [Patient Name]

**Date of Birth:** [DOB]

**Member ID:** [ID Number]

**Group Number:** [Group Number]

**Provider Information:**

**Requesting Physician:** [Physician Name]

**NPI Number:** [NPI Number]

**Phone:** [Phone Number]

**Requested Service:** Overnight Polysomnography (CPT: 95782/95783 or 95810/95811)

**Facility Name:** [Facility Name]

**Clinical Documentation:**

**Diagnosis Codes (ICD-10):**

[e.g., G47.33 Obstructive Sleep Apnea]

[e.g., J35.1 Hypertrophy of Tonsils]

**Symptoms and Medical Necessity:**

The patient presents with the following indications for a sleep study:

- [List symptoms: e.g., Snoring, witnessed gasping/apnea, restless sleep]
- [List comorbidities: e.g., Enlarged tonsils, ADHD, Down Syndrome, Obesity]
- [List failed treatments: e.g., Failed nasal steroids, persistent symptoms after T&A]

**Physician Statement:**

This pediatric sleep study is medically necessary to confirm a diagnosis of sleep-disordered breathing and to determine the appropriate course of treatment. Evaluation is required to prevent further complications including cardiovascular strain and developmental delays.

Please contact our office at [Phone Number] if you require additional medical records.

Sincerely,

[Physician Signature]

[Physician Printed Name]