[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Health Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Patient Name: [Patient Name]
Member ID Number: [ID Number]
Group Number: [Group Number]
Reference/Claim Number: [Denial Reference Number]
Type of Service: Sleep Study Diagnostic (CPT Code: [Insert Code])

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for a diagnostic sleep study requested by my healthcare provider, [Physician Name]. The request was denied on [Date of Denial] for the following reason: [Insert Reason from Denial Letter].

My physician has determined that a sleep study is medically necessary based on my clinical presentation, which includes: [List symptoms, e.g., chronic snoring, witnessed apnea, excessive daytime sleepiness, or high Epworth Sleepiness Scale score].

Furthermore, I meet the medical criteria for this diagnostic test due to the following co-morbidities: [List relevant conditions, e.g., hypertension, BMI over 35, or cardiovascular disease]. Failure to diagnose and treat a potential sleep disorder puts me at risk for more severe health complications.

Attached to this letter, please find:

- A letter of medical necessity from my treating physician.
- Clinical notes regarding my symptoms and physical examination.
- Relevant medical history and prior treatment attempts (if any).

I request that you reconsider your decision and approve the authorization for this essential diagnostic procedure. If you require further information, please contact me at [Phone Number] or my physician's office at [Physician Phone Number].

I look forward to a prompt response regarding this appeal.

Sincerely,

[Your Signature]
[Your Printed Name]