Date: [Date]

To: [Insurance Company Name]
Attention: Prior Authorization Department
Fax/Address: [Fax Number/Address]

RE: Prior Authorization Request for Multiple Sleep Latency Test (MSLT)

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Case Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to request prior authorization for a Multiple Sleep Latency Test (CPT Code 95805) to be performed in conjunction with a Polysomnogram (CPT Code 95810) for the above-referenced patient.

Clinical Justification:
The patient presents with symptoms of excessive daytime sleepiness (EDS) despite adequate nocturnal sleep. Clinical evaluation suggests a primary disorder of hypersomnolence. The MSLT is medically necessary to objectively measure sleep latency and identify Sleep Onset REM Periods (SOREMPs) to confirm a diagnosis of:

- [ ] Narcolepsy Type 1 (ICD-10: G47.411)
- [ ] Narcolepsy Type 2 (ICD-10: G47.419)
- [ ] Idiopathic Hypersomnia (ICD-10: G47.11)

Supporting Clinical History:

- **Epworth Sleepiness Scale Score:** [Score]/24
- **Duration of Symptoms:** [Number] months/years
- **Co-morbidities:** [e.g., Cataplexy, Sleep Paralysis, Hypnagogic Hallucinations]
- **Previous Treatments/Trials:** [List medications or CPAP trials if applicable]

The results of this test are critical for determining the appropriate pharmacological treatment plan and ensuring patient safety during daily activities. Attached please find the clinical notes and relevant medical history supporting this request.

Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]
[Phone Number]