

**Date:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** Prior Authorization Department

**FAX:** [Fax Number]

**PHONE:** [Phone Number]

**RE: Prior Authorization Request for Narcolepsy Diagnostic Testing**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Member ID:** [Member ID Number]

**Group Number:** [Group Number]

Dear Medical Review Board,

I am writing to request prior authorization for diagnostic sleep testing for the above-mentioned patient. Based on clinical evaluation, I suspect a diagnosis of Narcolepsy (ICD-10: G47.419 or G47.411).

**Requested Procedures:**

- CPT 95810: Polysomnography (PSG) - Attendance, Sleep Stages
- CPT 95805: Multiple Sleep Latency Test (MSLT)

**Clinical Justification:**

The patient presents with the following symptoms suggestive of Narcolepsy:

- [Symptoms: e.g., Chronic excessive daytime sleepiness for X months]
- [Symptoms: e.g., Suspected cataplexy or sudden loss of muscle tone]
- [Symptoms: e.g., Sleep paralysis or hypnagogic hallucinations]
- [Epworth Sleepiness Scale Score: X/24]

Standard screening and conservative treatments for other sleep disorders have been considered. An overnight PSG followed by a next-day MSLT is medically necessary to measure mean sleep latency and Sleep Onset REM Periods (SOREMPs) to confirm the diagnosis and initiate an appropriate pharmacological treatment plan.

Please contact my office at [Provider Phone Number] if further documentation is required. Thank you for your prompt attention to this request.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic/Facility Name]