

**Date:** [Date]

**To:** [Insurance Company Name]

**Attn:** Prior Authorization Department

**Fax/Address:** [Fax Number/Address]

**RE:** Maintenance of Wakefulness Test (MWT)

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Member ID:** [ID Number]

**Group Number:** [Group Number]

Dear Medical Director,

I am writing to request prior authorization for a Maintenance of Wakefulness Test (CPT Code 95805) for the above-mentioned patient. This test is medically necessary to assess the patient's ability to remain awake during the daytime and to evaluate the effectiveness of their current treatment plan.

**Clinical Documentation:**

- **Primary Diagnosis:** [e.g., Obstructive Sleep Apnea, Narcolepsy, Idiopathic Hypersomnia]
- **ICD-10 Code:** [Code]
- **Current Treatment:** [e.g., CPAP therapy, Modafinil, Sunosi]
- **Clinical Rationale:** [Briefly state if for occupational safety, assessing treatment efficacy, or legal requirements for driving.]

The patient has previously undergone a Polysomnogram (PSG) on [Date] and/or a Multiple Sleep Latency Test (MSLT) on [Date]. Despite adherence to therapy, the patient continues to experience [Symptoms]. The MWT results are critical for determining the safety of the patient performing daily activities and/or professional duties.

Enclosed are the clinical notes and relevant sleep study reports supporting this request. Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Name]

[NPI Number]

[Practice Name]