

Date: [Date]

To: [Insurance Company Name]

Attn: Prior Authorization Department

Fax/Address: [Fax Number or Mailing Address]

RE: Prior Authorization Request for Split-Night Sleep Study (CPT 95811)

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [Member ID Number]

Group Number: [Group Number]

Requesting Provider: [Physician Name], [NPI Number]

Facility Name: [Sleep Lab Name], [NPI Number]

To Whom It May Concern,

I am writing to request prior authorization for a Split-Night Sleep Study (Polysomnography with initiation of CPAP) for the above-referenced patient. This procedure is medically necessary to diagnose and treat the patient's suspected Obstructive Sleep Apnea (OSA).

Clinical Justification:

- **ICD-10 Diagnosis:** [e.g., G47.33 Obstructive Sleep Apnea]
- **Presenting Symptoms:** [e.g., Excessive daytime sleepiness, loud snoring, witnessed gasping/apneas, morning headaches]
- **Epworth Sleepiness Scale Score:** [Score]/24
- **Physical Findings:** [e.g., BMI of X, Mallampati Score of X, or Neck Circumference of X]
- **Comorbidities:** [e.g., Hypertension, Type 2 Diabetes, Atrial Fibrillation]

A split-night study is requested to allow for both the diagnostic recording and the titration of Continuous Positive Airway Pressure (CPAP) therapy during a single session, provided the patient meets the clinical criteria for apnea severity during the first half of the night. This approach is cost-effective and ensures the timely initiation of life-saving treatment.

Attached are the clinical notes and relevant medical records supporting this request. If you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Practice Name]