

**Date:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** Prior Authorization Department

**Fax/Phone:** [Fax Number / Phone Number]

**RE: Prior Authorization Request for Follow-Up Sleep Study**

**Patient Name:** [Patient First and Last Name]

**Date of Birth:** [MM/DD/YYYY]

**Member ID:** [Insurance 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 follow-up sleep study (Polysomnography) for the above-referenced patient. This diagnostic test is medically necessary to evaluate the efficacy of current treatment and/or to address persistent symptoms.

**Requested Procedure:**

- CPT Code: [e.g., 95810 or 95811]
- Description: [e.g., Follow-up Polysomnography / CPAP Titration Study]
- Place of Service: [In-lab or Home Sleep Test]

**Diagnosis Codes:**

- [ICD-10 Code, e.g., G47.33] - Obstructive Sleep Apnea
- [Other relevant codes]

**Clinical Justification:**

The patient was previously diagnosed with [Diagnosis] on [Original Date]. A follow-up study is required due to:

- [Significant weight gain/loss]
- [Persistent daytime sleepiness despite treatment compliance]
- [Inadequate response to current PAP settings]
- [Recent surgical intervention for airway management]

Enclosed please find the patient's clinical notes, original diagnostic results, and treatment compliance reports supporting this request.

Thank you for your prompt attention to this matter. If you require additional information, please contact my office at [Provider Phone Number].

Sincerely,

[Physician Name]

[NPI Number]

[Practice Name]

[Practice Address]