[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Prior Authorization Request for Pre-Operative Sleep Study

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request prior authorization for a diagnostic sleep study (CPT [Insert Code, e.g., 95810 or 95806]) for the above-referenced patient. This study is a mandatory medical prerequisite for the patient's upcoming bariatric surgery.

The patient has a diagnosis of Morbid Obesity (ICD-10 [Insert Code, e.g., E66.01]) with a BMI of [Patient BMI]. Screening indicates a high clinical suspicion of Obstructive Sleep Apnea (OSA). Clinical indicators include:

- [List symptoms: e.g., Excessive daytime somnolence, loud snoring, witnessed apnea]
- [List comorbidities: e.g., Hypertension, Type 2 Diabetes]

The sleep study is medically necessary to assess perioperative risk and to ensure patient safety during general anesthesia and the post-operative recovery phase. Identification and treatment of OSA prior to surgery significantly reduces the risk of respiratory failure, cardiac events, and sudden post-operative death.

Please find the attached clinical notes and screening tools supporting this request. Should you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]
[Practice Name]