[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

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

RE: Appeal for Denial of CPAP Equipment
Patient Name: [Patient Name]
Policy Number: [Insurance ID Number]
Group Number: [Group Number]
Claim Number/Reference Number: [Reference Number from Denial Letter]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for a Continuous Positive Airway Pressure (CPAP) machine and associated supplies, as prescribed by my physician, [Doctor's Name].

The denial letter dated [Date of Denial] stated that the equipment was denied because [Reason for denial stated in the letter]. However, this equipment is a medical necessity for the treatment of my diagnosed condition, Obstructive Sleep Apnea (OSA).

Clinical evidence supporting this request includes:

- **Diagnostic Sleep Study (Polysomnogram) Results:** My sleep study conducted on [Date] showed an Apnea-Hypopnea Index (AHI) of [Number], which confirms a diagnosis of [Mild/Moderate/Severe] Sleep Apnea.
- **Symptoms and Comorbidities:** Without CPAP therapy, I experience [List symptoms, e.g., excessive daytime sleepiness, gasping for air at night, or morning headaches]. My condition also increases my risk for [List comorbid conditions if applicable, e.g., hypertension, heart disease, or stroke].
- **Physician Recommendation:** [Doctor's Name] has determined that CPAP therapy is the gold standard of care for my condition and is necessary to maintain my health and safety.

Enclosed you will find copies of my sleep study results, the formal prescription, and a letter of medical necessity from my healthcare provider. These documents demonstrate that the requested equipment meets the criteria for coverage under my health plan.

I request that you reconsider this denial and approve coverage for the CPAP machine and necessary supplies immediately. I look forward to your written response within [Number of days, e.g., 30] days.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures:
- Copy of Denial Letter
- Sleep Study Results (PSG/HST)
- Physician Prescription
- Letter of Medical Necessity from [Doctor's Name]