

**Date:** [Insert Date]

**RE: Medical Necessity of CPAP Device for Travel**

**To Whom It May Concern,**

This letter is to certify that my patient, [**Patient Full Name**], Date of Birth: [**DOB**], is under my care for the treatment of Obstructive Sleep Apnea (OSA).

As part of the prescribed treatment plan, the patient requires the use of a Continuous Positive Airway Pressure (CPAP) machine. This device is a **prescribed medical necessity** and is required for use every night.

**Device Information:**

Brand/Model: [Insert Model Name/Number]

Serial Number: [Insert Serial Number]

Please note the following regarding the transportation of this medical equipment:

- This device is a life-sustaining medical instrument and should be handled with care.
- The device must stay with the patient as carry-on luggage to prevent damage or loss.
- In accordance with the Americans with Disabilities Act (ADA) and FAA/TSA regulations, medical devices do not count toward carry-on luggage limits.
- The device may require manual inspection or X-ray screening. Distilled water should be emptied from the humidifier chamber prior to security screening.

If you require further information or verification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

[Clinic/Hospital Name]

[NPI Number]

[Contact Address]