Date: [Date]

To: [Insurance Company Name]
Attention: [Department/Appeals Division]
Address: [Insurance Company Address]

RE: Letter of Medical Necessity for CPAP Therapy

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Member ID: [Insurance Member ID]
Policy Number: [Policy/Group Number]

To Whom It May Concern,

I am writing to formally request coverage for a Continuous Positive Airway Pressure (CPAP) machine and associated supplies for the above-mentioned patient. This equipment is medically necessary to treat a confirmed diagnosis of Obstructive Sleep Apnea (OSA).

Clinical Documentation:

- **Diagnosis:** [Primary Diagnosis, e.g., Obstructive Sleep Apnea, ICD-10 Code]
- **Sleep Study Date:** [Date of Polysomnogram or Home Sleep Test]
- **Apnea-Hypopnea Index (AHI):** [Insert AHI Score]
- **Oxygen Desaturation:** [Insert Lowest Oxygen Saturation Percentage]
- **Symptoms:** [List symptoms, e.g., Excessive daytime sleepiness, hypertension, gasping for air, etc.]

Prescribed Equipment:

- CPAP Device (HCPCS E0601)
- Humidifier (HCPCS E0562)
- Mask/Interface (HCPCS A7034, A7030, or A7027)
- Tubing and Filters

Based on the patient's clinical presentation and the results of the diagnostic sleep study, CPAP therapy is the gold standard of treatment and is essential to mitigate the risk of serious comorbidities including cardiovascular disease, stroke, and chronic fatigue. The patient is expected to use this device indefinitely to maintain airway patency during sleep.

Please contact my office at [Phone Number] if you require further documentation or clinical notes.

Sincerely,

[Physician Signature]
Physician Name: [Physician Name, MD/DO]
NPI Number: [Physician NPI]
Practice Name: [Clinic/Hospital Name]