Date: [Insert Date]

TO: [Insurance Company Name]
ATTN: Medical Review/Appeals Department
FAX/ADDRESS: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for CPAP Therapy
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Member ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally document the medical necessity of a Continuous Positive Airway Pressure (CPAP) device and related supplies for the above-mentioned patient.

Diagnosis:
The patient has been diagnosed with Obstructive Sleep Apnea (ICD-10 Code: G47.33) based on a clinical evaluation and a formal sleep study (Polysomnography) conducted on [Date of Sleep Study].

Clinical Findings:
The diagnostic results indicated an Apnea-Hypopnea Index (AHI) of [Insert AHI] and a minimum oxygen saturation (SaO2) of [Insert percentage]%. The patient currently exhibits the following symptoms:

- [Excessive daytime sleepiness]
- [Loud snoring and witnessed gasping/choking]
- [Morning headaches]
- [Co-morbidities: e.g., Hypertension, Atrial Fibrillation]

Treatment Plan:
Based on the severity of the diagnosis, I am prescribing the following equipment (HCPCS Codes):

- E0601: CPAP Device (with integrated heated humidifier)
- A7034/A7030: CPAP Interface (Mask)
- A7037: Tubing
- A7038/A7039: Filters

The use of a CPAP device is considered the gold standard for treating this condition and is essential to prevent long-term cardiovascular complications and improve the patient's daily functioning. The patient is motivated to comply with the therapy.

I request immediate approval for this life-sustaining medical equipment. Should you require additional documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
Physician Name: [Print Name]
NPI Number: [NPI Number]
Practice Name: [Clinic Name]