[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Subject: 60-Day CPAP/BiPAP Compliance Update

Dear [Patient Name],

This letter is to follow up on your progress with your sleep apnea therapy. Our records indicate that you have now been using your [CPAP/BiPAP] device for approximately 60 days.

To meet insurance requirements and ensure the effectiveness of your treatment, we have reviewed your device usage data. Your current compliance status is as follows:

- **Evaluation Period:** [Start Date] to [End Date]
- **Total Days Monitored:** [Number of Days]
- **Percentage of Days Used (>4 hours):** [Percentage]%
- **Average Hours of Use Per Night:** [Number of Hours]

Compliance Status: [Meeting Requirements / Not Meeting Requirements]

Most insurance providers require the device to be used for at least 4 hours per night for 70% of the time during a consecutive 30-day period within the first 90 days of therapy. Continued coverage for your equipment and supplies depends on meeting these criteria.

If you are experiencing difficulties such as mask discomfort, air leaks, or trouble falling asleep with the device, please contact our office at [Phone Number] or your equipment provider (DME) at [DME Phone Number] immediately. We are here to help you adjust to your therapy.

Please continue to use your device every night to ensure you receive the full benefits of your treatment.

Sincerely,

[Provider Name/Signature]
[Clinic/Facility Name]
[Phone Number]