[Date]

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

RE: Sleep Apnea Treatment Compliance Warning

Dear [Patient Name],

We are writing to you regarding your recent PAP (Positive Airway Pressure) therapy data. Upon reviewing your device usage records for the period of [Start Date] to [End Date], we have noted that your current usage does not meet the minimum requirements for effective treatment or insurance coverage.

Compliance Status:

- Total days monitored: [Number]
- Days used 4+ hours: [Number]
- Average usage per night: [Number] hours

To meet standard compliance guidelines, you must use your device for at least 4 hours per night on 70% of nights within a 30-day period. Consistent use is vital to manage your sleep apnea and reduce risks of cardiovascular issues, daytime fatigue, and other health complications.

Required Action:

If you are experiencing issues such as mask discomfort, air leaks, or pressure settings that feel too high or low, please contact our office at [Phone Number] immediately. We can schedule a mask fitting or a pressure adjustment to help you use the device more comfortably.

Please be advised that failure to meet compliance may result in your insurance provider denying coverage for your equipment, which could lead to the repossession of the device or out-of-pocket billing.

We are committed to helping you succeed with your therapy. Please reach out to us as soon as possible to address any barriers to your treatment.

Sincerely,

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