

# Letter of Medical Necessity

Patient's Name \_\_\_\_\_

Patient's Address \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

To Whom it may concern:

This letter serves as a request and clinical justification for the above-referenced patient to obtain a Sleep Sentry™ monitor. The patient exhibits the following signs, symptoms, and/or conditions and would benefit greatly by having the Sleep Sentry™ monitor to alert for symptoms of hypoglycemia while sleeping. With the sounding of this alarm the patient can test their blood glucose level and take corrective action if necessary before a more serious condition develops.

**Patient with diabetes has one or more of the following:**

- History of nocturnal hypoglycemic events
- History of nocturnal hypoglycemia events requiring assistance (including coma/seizure)

Additional Comments:

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If you have any questions about this request, please feel free to contact me. I would be more than willing to discuss this situation or case with you.

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Physician's Phone #

\_\_\_\_\_  
Physician's Fax #