URGENT: EXPEDITED RECOGNITION REQUEST
Subject: Letter of Medical Necessity for Out-of-Network Referral

Date: [Date]

TO: [Insurance Company Name]
ATTN: Utilization Management / Appeals Department
Fax Number: [Fax Number]

PATIENT INFORMATION:
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]

PHYSICIAN INFORMATION:
Referring Provider: [Name]
NPI Number: [NPI Number]
Phone/Fax: [Phone/Fax]

REQUESTED OUT-OF-NETWORK PROVIDER:
Specialist Name: [Specialist Name]
Specialty: [Specialty]
Facility: [Facility Name]
Address: [Address]

CLINICAL JUSTIFICATION:

This letter is to request an expedited out-of-network referral for the patient named above. This request is based on **medical necessity** due to the following reasons:

- **Diagnosis:** [Insert Primary Diagnosis and ICD-10 Code]
- **Clinical Urgency:** [Explain why the patient's condition requires immediate intervention to prevent serious jeopardy to life, health, or the ability to regain maximum function.]
- **Lack of In-Network Availability:** [State that there are no qualified in-network specialists within a reasonable geographic distance OR that in-network wait times exceed the clinical safety window.]
- **Unique Expertise:** [Describe the specific procedure or specialized expertise offered by the out-of-network provider that is not available through in-network providers.]

SUPPORTING DOCUMENTATION ATTACHED:
[List: e.g., Clinical Notes, Diagnostic Results, In-Network Provider Search Logs]

Failure to approve this expedited request may result in [Describe potential negative health outcome]. Please provide a determination within [Number of hours, e.g., 24-72] hours as per the expedited review guidelines.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Practice Name]