URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST
CLINICAL URGENCY: LIFE-THREATENING CONDITION

Date: [Insert Date]

TO:
[Insurance Company Name]
Prior Authorization Department
Fax: [Insert Fax Number]
Phone: [Insert Phone Number]

RE: Patient Information
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [ID Number]
Group Number: [Group Number]
Policy Holder: [Name of Policy Holder]

Provider Information:
Requesting Physician: [Surgeon Name]
NPI Number: [NPI Number]
Facility Name: [Hospital/Clinic Name]
Facility Tax ID: [Tax ID Number]
Contact Person: [Name/Direct Phone Number]

Requested Procedure:
CPT Code(s): [e.g., 33533 - CABG, single arterial graft]
ICD-10 Diagnosis Code(s): [e.g., I25.10 - ASHD]
Proposed Date of Surgery: [Date]

Clinical Justification:
This is a formal request for an **expedited** review of a Coronary Artery Bypass Graft (CABG) surgery. The patient presents with [List symptoms, e.g., unstable angina, critical left main stenosis, or multi-vessel disease].

Standard authorization timeframes will seriously jeopardize the life and/or health of the patient or the patient's ability to regain maximum function. Immediate surgical intervention is required because [Provide brief clinical reason for urgency].

Attached Documentation:
- Cardiac Catheterization/Angiography Report
- Recent EKG/Echocardiogram Results
- Physician Consultation Notes
- Relevant Lab Work

Please provide a determination within [Insert Number, e.g., 24] hours. Thank you for your immediate attention to this life-saving request.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Title]