URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST
CLINICAL INDICATOR: POTENTIAL PERMANENT NEUROLOGICAL DEFICIT

Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization/Utilization Management Department
FAX: [Fax Number]

RE: Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]

Provider Name: [Surgeon Name]
NPI Number: [NPI Number]
Facility Name: [Hospital/Surgical Center Name]

To Whom It May Concern,

This letter is to request an **expedited prior authorization** for urgent spinal decompression surgery (CPT Code: [Insert Code, e.g., 63030]) for the above-referenced patient. Due to the acute nature of the patient's clinical presentation, a standard review timeframe could seriously jeopardize the patient's life, health, or ability to regain maximum function.

Clinical Diagnosis: [Insert Diagnosis, e.g., Acute Lumbar Disc Herniation with Cauda Equina Syndrome / Severe Spinal Stenosis]
ICD-10 Code: [Insert ICD-10 Code]

Clinical Justification for Expedited Status:
The patient is currently experiencing the following acute symptoms:

- [Insert Symptom, e.g., Rapidly progressing motor weakness]
- [Insert Symptom, e.g., Loss of bowel/bladder control]
- [Insert Symptom, e.g., Intractable pain unresponsive to conservative management]
- [Insert Symptom, e.g., Saddle anesthesia]

Imaging (MRI/CT dated [Date]) confirms [Insert Findings, e.g., severe canal compromise at L4-L5]. Immediate surgical intervention is required to prevent permanent neurological damage.

Please provide a determination within 24 hours. If you have questions or require further clinical documentation, please contact my office immediately at [Phone Number].

Sincerely,

[Surgeon Signature]
[Surgeon Printed Name]
[Practice Name]