URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST

Date: [Insert Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department / Medical Director
Fax Number: [Insert Fax Number]

RE: Patient Information
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insert ID Number]
Group Number: [Insert Group Number]
Case Reference Number: [If applicable]

Provider Information
Requesting Physician: [Physician Name]
NPI Number: [Insert NPI]
Phone: [Insert Phone Number]
Fax: [Insert Fax Number]

Requested Intervention/Procedure: [Insert Procedure Name, e.g., Emergency Thrombectomy, Urgent Spinal Decompression]
CPT/HCPCS Codes: [Insert Codes]
ICD-10 Diagnosis Codes: [Insert Diagnosis Codes]

Clinical Justification:
This is an expedited request for a neurological intervention that is medically necessary due to the patient's acute condition. The patient presents with [Briefly list symptoms, e.g., progressive focal neurological deficits, acute spinal cord compression, or intracranial pressure]. Delay in treatment poses a significant risk of permanent neurological damage, loss of function, or life-threatening complications.

Clinical Rationale:
[Briefly describe recent imaging results or clinical findings]. Based on these findings, immediate intervention is required to [State goal, e.g., prevent paralysis or restore blood flow].

Request for Immediate Decision:
Due to the urgent nature of this neurological condition, I am requesting an expedited review and determination within [Insert Timeframe, e.g., 24 hours].

Please contact my office immediately at [Insert Phone Number] with the authorization number or if further clinical documentation is required.

Sincerely,

[Physician Signature]
[Physician Name, Title]