URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST
TYPE: INPATIENT PSYCHIATRIC ADMISSION

Date: [Date]

TO: [Insurance Company Name]
ATTN: Utilization Management / Behavioral Health Department
FAX: [Fax Number]
PHONE: [Phone Number]

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

PROVIDER INFORMATION
Admitting Facility: [Facility Name]
Facility NPI: [NPI Number]
Attending Physician: [Physician Name]
Contact Phone/Fax: [Phone/Fax Number]

CLINICAL JUSTIFICATION

Requested Date of Admission: [Date]
ICD-10 Diagnosis Codes: [Primary and Secondary Codes]

Current Clinical Status:
[Insert brief description of acute symptoms, e.g., active suicidal ideation with plan, homicidal ideation, or profound inability to care for self due to psychosis/mania.]

Medical Necessity Statement:
The patient meets the criteria for inpatient psychiatric hospitalization due to a high risk of harm to [self/others/both]. Less restrictive levels of care have been considered and deemed insufficient to ensure patient safety and stabilization. Delayed authorization poses a significant threat to the patient's life and health.

Requested Action:
Please provide an expedited review and authorization for [Number] days of acute inpatient care. Please notify the facility of the determination via fax at [Fax Number] or phone at [Phone Number].

Sincerely,

[Your Name/Signature]
[Your Title/Role]
[Organization Name]