URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST

Date: [Date]
To: [Insurance Company Name]
Attention: Utilization Management / Prior Authorization Department
Fax/Email: [Fax Number or Email Address]

Patient Information:

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

Provider Information:

- **Requesting Physician:** [Physician Name]
- **NPI Number:** [NPI Number]
- **Facility Name:** [Facility Name where procedure will be performed]
- **Contact Phone:** [Phone Number]
- **Contact Fax:** [Fax Number]

Clinical Request:

- **Procedure Requested:** [e.g., EGD, Colonoscopy, ERCP]
- **CPT Code(s):** [Insert Code(s)]
- **ICD-10 Diagnosis Code(s):** [Insert Code(s)]
- **Proposed Date of Service:** [Date]

Clinical Justification for Expedited Review:

This request is for an **expedited/urgent** review because the standard authorization timeframe could seriously jeopardize the patient's life, health, or ability to regain maximum function.

Medical Necessity Summary:

The patient presents with [List urgent symptoms, e.g., acute GI bleeding, severe dysphagia, suspected malignancy, or intractable pain]. [Briefly describe failed conservative treatments or relevant diagnostic findings]. Immediate endoscopic intervention is required to [State goal: e.g., identify source of bleeding, obtain biopsy, or relieve obstruction].

Please process this request within the expedited timeframe (typically 24-72 hours). Supporting clinical documentation and office notes are attached.

Sincerely,

[Physician Signature]
[Physician Name, Title]