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

**Physician Information**
**Requesting Surgeon:** [Insert Surgeon Name]
**NPI Number:** [Insert NPI]
**Facility Name:** [Insert Hospital/Facility Name]
**Phone/Fax:** [Insert Contact Info]

**Diagnosis:** [Insert Diagnosis, e.g., Acute Cholecystitis / Symptomatic Cholelithiasis]
**ICD-10 Code:** [Insert Code, e.g., K80.00]
**Procedure Requested:** Cholecystectomy (CPT: 47562 or 47563)

**Clinical Justification:**
This is a formal request for an **expedited** review for a medically necessary cholecystectomy. The patient is currently presenting with symptoms that require urgent surgical intervention to prevent further complications, including [Insert complications, e.g., biliary colic, gallbladder perforation, or pancreatitis].

The patient has failed conservative management and meets the clinical criteria for urgent surgery based on the following findings:
[List Key Findings: e.g., Ultrasound results showing gallstones/wall thickening, elevated WBC count, or severe RUQ pain].

A delay in this procedure could seriously jeopardize the patient's life, health, or ability to regain maximum function. Therefore, we request a determination within [Insert Timeframe, e.g., 24-48 hours].

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

Sincerely,

[Physician Signature]
[Physician Printed Name]