URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST

Date: [Insert Date]
To: [Health Insurance Company Name]
Attention: Utilization Management/Prior Authorization Department
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]

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

Service Requested
Procedure: [Insert Specific MRI Type, e.g., MRI Brain with and without contrast]
CPT Code: [Insert CPT Code]
Diagnosis: [Insert Diagnosis Name and ICD-10 Code]

Urgency Statement:
This is a request for an **Expedited/Urgent** review. Applying the standard turnaround time could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Clinical Justification:
The patient presents with [List acute symptoms or clinical indications]. This MRI is medically necessary for immediate diagnostic evaluation to determine the course of treatment for [Reason for urgency].

Relevant Previous Treatments/Tests:
[List failed treatments, conservative therapies, or relevant X-ray/CT results]

Please provide a determination within [Insert Number, e.g., 24 or 72] hours. If you require additional information, please contact my office immediately at [Insert Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]