URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST
CLINICAL CONDITION: ACUTE PULMONARY EMBOLISM

Date: [Date]

To: [Insurance Provider Name]
Attention: Utilization Management / Prior Authorization Department
Fax Number: [Fax Number]

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

Provider Name: [Physician Name]
NPI Number: [NPI Number]
Phone Number: [Phone Number]
Facility Name: [Hospital/Clinic Name]

Requested Treatment/Procedure: [Insert Treatment, e.g., Thrombectomy, Catheter-Directed Thrombolysis, or Specific Medication]
ICD-10 Code: [Insert Code, e.g., I26.99]

To Whom It May Concern,

This is a formal request for an **expedited** review of a life-critical treatment for the patient listed above who has been diagnosed with an acute Pulmonary Embolism (PE). Standard review timeframes will place the patient's life and health in serious jeopardy.

Clinical Justification:
The patient presented with [Symptoms: e.g., acute shortness of breath, chest pain, tachycardia]. Diagnosis was confirmed via [Diagnostic Test: e.g., CT Angiogram/V/Q Scan] on [Date]. Current clinical markers indicate [List severity: e.g., Right Ventricular strain, hemodynamic instability, or high PESI score].

Immediate intervention is medically necessary to prevent right heart failure, pulmonary infarction, or sudden cardiac death. The requested treatment is the recognized standard of care for this acute presentation.

Please provide a determination within [Number, e.g., 24] hours. If you require further clinical documentation, please contact my office immediately at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Title]