URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST
MEDICAL NECESSITY: TIME-SENSITIVE SURGERY

Date: [Insert Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department / Medical Review

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

Provider Information
Requesting Surgeon: [Surgeon Name]
NPI Number: [NPI Number]
Facility Name: [Hospital/Surgery Center Name]
Tax ID: [Tax ID Number]

Clinical Information
Diagnosis: [e.g., Rhegmatogenous Retinal Detachment, ICD-10: H33.00]
Procedure Requested: [e.g., Pars Plana Vitrectomy / Scleral Buckle, CPT: 67108]
Requested Date of Service: [Date or "ASAP"]

To Whom It May Concern,

This is a formal request for an **expedited prior authorization** for an emergency surgical repair of a retinal detachment. This condition is a sight-threatening emergency. Delayed intervention will likely result in permanent, irreversible vision loss for the patient.

Clinical findings include: [Briefly list findings, e.g., Macula-on status, vitreous hemorrhage, or progressive field loss].

Due to the acute nature of this condition, we request a determination within 24 hours. Please find the attached clinical notes and diagnostic imaging confirming the diagnosis.

Please contact our office immediately via telephone at [Phone Number] or fax at [Fax Number] with the authorization number.

Sincerely,

[Surgeon Signature]
[Surgeon Printed Name]
[Practice Name]