**URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST**
**RE: URGENT HEMODIALYSIS INITIATION**

**Date:** [Date]

**TO:** [Insurance Company Name]
**ATTN:** Prior Authorization Department / Utilization Management
**Fax Number:** [Fax Number]

**PATIENT INFORMATION:**
**Name:** [Patient Name]
**Date of Birth:** [DOB]
**Member ID:** [Member ID Number]
**Policy/Group Number:** [Group Number]

**PROVIDER INFORMATION:**
**Requesting Physician:** [Physician Name]
**NPI Number:** [NPI Number]
**Facility Name:** [Facility Name]
**Phone/Fax:** [Phone/Fax Number]

**CLINICAL JUSTIFICATION:**

This is a formal request for **expedited** prior authorization for the initiation of outpatient hemodialysis. A standard 72-hour review timeframe will seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Diagnosis:** [e.g., End Stage Renal Disease (ESRD) - ICD-10: N18.6]
**Current Lab Values:** GFR: [Value], Creatinine: [Value], Potassium: [Value]
**Clinical Indication:** [e.g., Uremia, Refractory Fluid Overload, Hyperkalemia]

The patient requires immediate dialysis treatment to prevent acute metabolic emergency or hospitalization. Delay in treatment poses a significant risk of cardiac arrest or pulmonary edema.

**REQUESTED SERVICES:**
- Procedure Code: [e.g., CPT 90935 / 90937]
- Frequency: [e.g., 3 times per week]
- Start Date: [Requested Start Date]

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

Sincerely,

[Physician Signature]
[Physician Name, Title]