URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST
Medical Necessity for Urgent Epidural Steroid Injection

Date: [Date]

To: [Insurance Company Name]
Attn: Prior Authorization Department / Medical Director
Fax Number: [Fax Number]

RE: Patient Information
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID]
Group Number: [Group Number]
Case/Reference Number: [If applicable]

Provider Information:
Requesting Physician: [Physician Name]
NPI Number: [NPI Number]
Clinic Contact: [Name and Phone Number]

Requested Procedure: [e.g., Lumbar Transforaminal Epidural Steroid Injection]
CPT Code(s): [e.g., 62323, 64483]
ICD-10 Diagnosis Code: [e.g., M54.16 - Lumbar Radiculopathy]

Clinical Justification for Expedited Review:
I am requesting an **expedited (72-hour) review** of this request. A standard review timeframe may seriously jeopardize the patient's life, health, or ability to regain maximum function. The patient is currently experiencing:

- Severe, intractable pain (rated [X]/10) unresponsive to conservative management.
- Acute neurological deficits (e.g., motor weakness, sensory loss).
- Impaired activities of daily living and inability to maintain basic mobility.

Clinical Summary:
The patient presents with [Briefly describe symptoms and duration]. Imaging ([MRI/CT Date]) confirms [List specific findings, e.g., L4-L5 disc herniation with nerve root compression]. To date, the patient has failed the following conservative treatments:

- [List Medications tried: e.g., NSAIDs, Gabapentinoids]
- [List Physical Therapy or Chiropractic sessions and dates]
- [List other interventions]

The requested Epidural Steroid Injection is medically necessary to reduce acute inflammation, alleviate debilitating pain, and prevent further neurological deterioration or potential surgical intervention.

Thank you for your immediate attention to this urgent matter.

Sincerely,

[Physician Signature]
[Physician Printed Name]