URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST
Clinical Urgency: High - Potential for Limb or Life Threat

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

RE: Patient Information
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID Number: [Insert ID Number]
Group Number: [Insert Group Number]

Provider Information
Requesting Physician: [Physician Name]
NPI Number: [Insert NPI]
Facility Name: [Insert Facility Name]
Phone/Fax: [Insert Contact Info]

Requested Service
Procedure: Urgent Advanced Wound Debridement (CPT: [Insert Code, e.g., 11042-11047])
Diagnosis: [Insert ICD-10 Code and Description, e.g., Non-healing diabetic foot ulcer with necrosis]
Scheduled Date: [Insert Date or "As soon as approved"]

To Whom It May Concern,

I am writing to request an **expedited** prior authorization for advanced wound debridement for the aforementioned patient. A standard review timeframe could seriously jeopardize the patient's life, health, or ability to regain maximum function.

Clinical Justification:
The patient presents with [Describe wound severity: e.g., Stage IV pressure injury, infected necrotic tissue, or gangrene]. Current clinical findings include [List symptoms: e.g., purulent drainage, escalating pain, or signs of systemic infection].

Failure to perform immediate debridement places the patient at high risk for:
- Sepsis
- Osteomyelitis
- Amputation of the affected limb
- Significant tissue loss

Previous Treatments:
The patient has previously attempted [List conservative treatments: e.g., topical dressings, oral

antibiotics, or standard wound care] without success. Surgical intervention is now medically necessary to remove devitalized tissue and promote healing.

Attached please find clinical notes, wound measurements, and photographs supporting this urgent request. Please process this request within the 72-hour expedited window (or sooner) as mandated by clinical urgency.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]