Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization/Appeals Department
FAX/ADDRESS: [Fax Number or Mailing Address]

RE: Retroactive Prior Authorization Request for Emergency Cardiac Care
Patient Name: [Patient Full Name]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Date of Birth: [MM/DD/YYYY]
Date of Service: [Start Date] to [End Date]
Claim Number (if applicable): [Claim Number]

To Whom It May Concern,

This letter serves as a formal request for a retroactive prior authorization for emergency cardiac services provided to the above-referenced patient. Due to the life-threatening and emergent nature of the patient's condition, immediate medical intervention was required before authorization could be obtained.

Clinical Summary:

On [Date], the patient presented with acute symptoms including [list symptoms, e.g., crushing chest pain, shortness of breath, cardiac arrest]. Based on the emergency clinical presentation, the patient was diagnosed with [Diagnosis/ICD-10 Code].

Emergency Procedures Performed:

- [Procedure Name / CPT Code]
- [Procedure Name / CPT Code]
- [Procedure Name / CPT Code]

Justification for Retroactive Approval:

Under the Emergency Medical Treatment and Labor Act (EMTALA) and standard medical necessity guidelines, the delay of care to seek prior authorization would have resulted in severe permanent damage or the death of the patient. The acuity of the cardiac event necessitated immediate stabilization and treatment.

Attached please find the emergency department notes, operative reports, and discharge summary supporting the medical necessity of these services. We request that you review this clinical documentation and grant retroactive authorization to ensure appropriate processing of the associated claims.

Thank you for your prompt attention to this matter. Should you require further information, please contact [Contact Name] at [Phone Number].

Sincerely,

[Physician Name/Signature]
[Provider NPI Number]
[Facility Name]
[Contact Phone/Email]