[Date]

[Insurance Company Name]
[Attn: Prior Authorization/Appeals Department]
[Insurance Company Address]
[City, State, Zip Code]

RE: Request for Emergency Retroactive Prior Authorization
Patient Name: [Patient First and Last Name]
Patient Date of Birth: [MM/DD/YYYY]
Member ID Number: [ID Number]
Group Number: [Group Number]
Date of Service: [Date Service was Provided]
Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

This letter is a formal request for a retroactive prior authorization for emergency outpatient services provided to the above-referenced patient at [Clinic Name] on [Date of Service].

The patient presented to our facility with the following emergency symptoms: [Briefly list symptoms, e.g., acute chest pain, severe allergic reaction, respiratory distress]. Due to the immediate and life-threatening nature of the patient's condition, clinical intervention was required immediately to stabilize the patient and prevent serious jeopardy to their health.

Because of the emergency nature of this visit, it was not possible to obtain prior authorization before treatment was initiated. Under [State Law or Policy Name, if known] and the Emergency Medical Treatment and Labor Act (EMTALA) guidelines, stabilizing care was prioritized to ensure patient safety.

Attached you will find the clinical documentation, including the emergency encounter notes, vital signs, and diagnostic results that support the medical necessity of this emergency outpatient visit.

We kindly request that you review this information and grant a retroactive authorization so that the claim may be processed for payment. If you require additional information, please contact our billing department at [Phone Number] or via email at [Email Address].

Sincerely,

[Authorized Signature]
[Printed Name and Title]
[Clinic Name]
[Tax ID/NPI Number]