[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email]

[Date]

[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Urgent Medical Clinic Retroactive Prior Authorization Appeal

Patient Name: [Patient Full Name]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Claim Number: [Claim Number]
Date of Service: [Date of Visit]
Facility Name: [Urgent Care Clinic Name]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for services rendered at [Urgent Care Clinic Name] on [Date of Service]. The claim was denied due to a lack of prior authorization. I am requesting a retroactive authorization and reconsideration of this claim based on the medical urgency of the situation.

On the date of service, I experienced the following symptoms: [Briefly describe symptoms, e.g., high fever, severe pain, acute injury]. Due to the sudden onset and severity of these symptoms, I required immediate medical intervention. Seeking care at an urgent medical clinic was necessary to prevent the worsening of my condition and to avoid an unnecessary emergency room visit.

At the time of treatment, the primary focus was ensuring my medical stability. Because of the urgent nature of the visit, there was no opportunity to obtain prior authorization before the services were rendered. [Optional: Attach any medical records or doctor's notes supporting the urgency].

I request that you review the attached medical documentation and approve this retroactive authorization so that the claim may be processed for payment. Please notify me of your decision in writing within the required timeframe.

Thank you for your time and attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List attached documents, such as medical records or discharge papers]