Date: [Date]

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

RE: Retroactive Prior Authorization Request for Emergency Services

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Date of Service: [Date of Visit]
Claim Number: [Claim Number (if applicable)]

To Whom It May Concern,

This letter is to formally request a retroactive prior authorization for an emergency clinic visit for the above-mentioned patient on [Date of Service].

Clinical Justification:
The patient presented to our facility with the following acute symptoms: [List symptoms, e.g., severe chest pain, high fever, acute injury]. Based on the clinical presentation, the patient required immediate medical intervention to prevent serious jeopardy to their health, impairment to bodily functions, or serious dysfunction of a bodily organ.

Reason for Retroactive Request:
Due to the emergent and life-threatening nature of the patient's condition, immediate stabilization and treatment were prioritized over the standard prior authorization process. Obtaining advance approval was not feasible without compromising patient safety.

Services Rendered:
[Briefly list tests or procedures, e.g., EKG, X-ray, Blood Work, Sutures].

Attached you will find the clinical notes and discharge summary supporting the medical necessity of this emergency visit. Please process this authorization so that the associated claims may be adjudicated accordingly.

If you require further information, please contact our office at [Phone Number].

Sincerely,

[Doctor/Provider Name]
[NPI Number]
[Clinic/Facility Name]