Date: [Date]

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

RE: Retroactive Prior Authorization Request for Emergency Services

Patient Information:
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Claim Number: [Claim Number, if applicable]

Provider Information:
Clinic Name: [Clinic Name]
NPI Number: [Clinic NPI]
Tax ID: [Tax ID]
Contact Person: [Name of Contact]
Phone Number: [Phone Number]

Service Information:
Date of Service: [Date of Emergency Treatment]
ICD-10 Code(s): [Diagnosis Codes]
CPT/HCPCS Code(s): [Procedure Codes]

Dear Prior Authorization Department,

This letter serves as a formal request for a retroactive prior authorization for emergency medical services provided to the above-referenced patient on [Date of Service].

The patient presented to our facility with an emergency medical condition involving [briefly describe symptoms, e.g., acute respiratory distress, severe hemorrhaging, or chest pain]. Due to the immediate threat to the patient's health and the urgent nature of the treatment required, prior authorization could not be obtained at the time of service.

As per the Emergency Medical Treatment and Labor Act (EMTALA) and the terms of the patient's health plan regarding emergency care, we request that you review the attached clinical documentation and approve the services rendered.

Attached Documentation:
- Emergency Room / Clinic Visit Notes
- Diagnostic Results
- Treatment Summary

Thank you for your prompt attention to this matter. If you require additional information, please contact our billing department at [Phone Number].

Sincerely,

[Signature]
[Printed Name and Title]
[Clinic Name]