[Date]

To: [Health Plan Name]
Department: Utilization Management / Appeals
Fax/Address: [Fax Number or Mailing Address]

RE: Post-Service Emergency Stabilization Retroactive Prior Authorization

Patient Name: [Patient First and Last Name]
Member ID: [Insurance ID Number]
Date of Birth: [MM/DD/YYYY]
Claim/Reference Number: [Number if applicable]
Date(s) of Service: [Start Date] to [End Date]

To Whom It May Concern,

This letter is a formal request for a retroactive prior authorization for emergency stabilization services provided to the above-referenced member at [Facility Name].

Clinical Justification:
The patient presented to the emergency department with [Briefly describe acute symptoms, e.g., severe chest pain, respiratory distress, or trauma]. Following initial triage, the patient was determined to be unstable, requiring immediate medical intervention to prevent serious jeopardy to their health, impairment to bodily functions, or serious dysfunction of a bodily organ.

Emergency Stabilization:
Pursuant to the Emergency Medical Treatment and Labor Act (EMTALA), the clinical team proceeded with necessary stabilization services, including [List key procedures or tests, e.g., emergency surgery, ICU admission, or continuous monitoring]. Due to the emergent and life-threatening nature of the patient's condition, it was not medically feasible to delay treatment to obtain prospective authorization.

Documentation Attached:
Enclosed please find the medical records supporting this request, including:
- Emergency Department admission notes
- Physician progress notes regarding stabilization
- Relevant diagnostic results

We request that you review this clinical information and grant retroactive authorization for the services rendered. Please contact our office at [Phone Number] if you require further information.

Sincerely,

[Signature]
[Name of Provider or Facility Representative]

[Title]
[Organization Name]
[Tax ID/NPI Number]