[Date]

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

RE: Urgent Retroactive Prior Authorization Request

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Claim Number: [Claim #, if applicable]
Date of Service: [Date of Service]

To Whom It May Concern,

This letter is a formal request for a retroactive prior authorization for urgent care services provided to the above-mentioned patient on [Date of Service].

The patient presented to our clinic with the following symptoms: [List symptoms]. Based on the clinical presentation, immediate medical intervention was required to prevent a serious deterioration of the patient's health. The following procedure(s)/treatment(s) were performed: [List codes/services].

A retroactive authorization is requested because:

- The patient required immediate stabilization and treatment.
- The urgency of the medical condition precluded obtaining authorization prior to treatment.
- [Optional: Additional reason, e.g., clinic was unaware of coverage requirements at time of emergency].

Attached are the clinical notes and medical records supporting the medical necessity of this urgent visit. We kindly request that you review this information and grant a retroactive approval for these services.

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

Sincerely,

[Provider Name/Signature]
[Clinic Name]
[Tax ID/NPI Number]