[Your Name/Organization Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Address Line 1]
[City, State, Zip Code]

RE: Retroactive Prior Authorization Request for Emergency Services

Patient Name: [Patient Full Name]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Date of Birth: [MM/DD/YYYY]
Date of Service: [MM/DD/YYYY]
Claim/Reference Number: [If applicable]

To Whom It May Concern,

This letter is 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 [Facility Name] with a medical emergency consisting of [briefly describe emergency symptoms, e.g., severe chest pain, loss of consciousness, acute trauma]. Due to the life-threatening nature of the condition and the immediate need for stabilization, prior authorization could not be obtained at the time of admission.

As per the Emergency Medical Treatment and Labor Act (EMTALA) and the "Prudent Layperson Standard," the services provided were medically necessary to prevent serious impairment to the patient's health. Authorization was bypassed solely to ensure the delivery of life-saving care without delay.

Attached please find the following supporting documentation:

- Emergency Department admission notes
- Physician's clinical summary
- Discharge summary (if applicable)
- Relevant diagnostic test results

We kindly request that you review this submission and grant retroactive authorization so that the claim may be processed for payment. If you require additional information, please contact [Contact Name] at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Printed Name and Title]