[Date]

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

**RE: Retroactive Prior Authorization Request for Emergency Surgery**

**Patient Name:** [Patient Name]
**Policy Number:** [Policy Number]
**Group Number:** [Group Number]
**Date of Birth:** [DOB]
**Date of Service:** [Date of Surgery]
**Claim/Reference Number:** [If applicable]

To Whom It May Concern,

This letter is a formal request for a retroactive prior authorization for an emergency surgical procedure performed on [Date] at [Facility Name] by Dr. [Surgeon Name].

The patient presented with an acute, life-threatening condition consisting of [Brief Description of Emergency, e.g., acute appendicitis, traumatic injury]. Due to the immediate risk to the patient's life and health, there was no opportunity to obtain prior authorization before the surgical intervention was required.

**Clinical Justification:**

- **ICD-10 Diagnosis Code:** [Code] - [Description]
- **CPT Procedure Code:** [Code] - [Description]
- **Emergency Nature:** [Briefly describe why the surgery could not be delayed, e.g., risk of organ failure, hemorrhage].

Attached are the operative reports, emergency room intake notes, and clinical documentation supporting the medical necessity and emergency status of this procedure.

We request that you review this claim for retroactive approval so that the provider may be reimbursed for these essential services. If you require further information, please contact our office at [Phone Number] or [Email Address].

Sincerely,

[Your Signature]
[Your Printed Name]
[Provider/Facility Name]
[NPI Number]