Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization/Appeals Department
FAX: [Fax Number]

RE: Letter of Medical Necessity for Retroactive Emergency Prior Authorization
Patient Name: [Patient First and Last Name]
Patient Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Claim/Reference Number: [Claim Number if applicable]
Date of Service: [Date of Visit]

To Whom It May Concern,

I am writing to formally request a retroactive prior authorization for emergency services provided to the above-named patient at [Clinic/Facility Name] on [Date of Service].

Clinical Justification:
The patient presented with an acute onset of [Symptoms/Condition, e.g., severe chest pain, respiratory distress, high fever]. Based on the "Prudent Layperson Standard," the severity of the symptoms required immediate medical intervention to prevent serious jeopardy to the patient's health, impairment of bodily functions, or serious dysfunction of an organ or part.

Emergency Nature:
Due to the life-threatening and emergent nature of the situation, the patient was unable to seek prior authorization before receiving care. Immediate stabilizing treatment was medically necessary and could not be delayed. [Include brief clinical detail: e.g., The patient's vitals were unstable, requiring immediate IV medication and diagnostic imaging.]

Requested Action:
Based on the emergency medical necessity documented in the attached medical records, I request that you waive the prior authorization requirement and process this claim for full payment.

Included with this letter are the clinical notes and discharge summary for your review.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]
[Facility Name/Address]
[Phone Number]