[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email]

[Date]

[Insurance Company Name]
[Claims/Prior Authorization Department]
[Address]
[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 Service: [Date of Visit]
Facility Name: [Emergency Clinic Name]
Claim Number (if applicable): [Claim Number]

To Whom It May Concern,

I am writing to formally request a retroactive prior authorization for emergency medical services received at [Emergency Clinic Name] on [Date].

On the date mentioned above, I experienced an emergency medical condition involving [briefly describe symptoms, e.g., severe chest pain, uncontrollable bleeding, or loss of consciousness]. Due to the acute and life-threatening nature of the symptoms, I sought immediate care at the nearest available facility to prevent serious jeopardy to my health, as defined by the "Prudent Layperson Standard."

Because this was an unplanned emergency situation, it was not possible to obtain prior authorization or ensure the facility was within the preferred provider network before treatment was administered. Under the No Surprises Act and federal emergency care guidelines, emergency services should be covered at the in-network benefit level regardless of the facility's network status.

Attached please find the following supporting documentation:
- Emergency department medical records and discharge summary
- A copy of the billing statement
- [Any other relevant medical notes]

I request that you review this claim and grant retroactive authorization so that the services may be processed at the in-network rate. Please notify me of your decision in writing within the standard regulatory timeframe.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]