Date: [Date]

[Health Plan Name]
[Utilization Management Department]
[Address]
[City, State, Zip]

RE: Peer-to-Peer Review Summary and Authorization Request

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Reference/Reference Number: [Reference Number]
Date of Service: [Date of Service]

To Whom It May Concern,

This letter follows the peer-to-peer clinical discussion held on [Date] between [Requesting Physician Name] and [Medical Director Name] regarding the requested [Service/Procedure/Medication].

Clinical Summary:
The patient presents with [Diagnosis/Symptoms]. Based on clinical evaluation, the requested [Service/Procedure] is medically necessary because [Brief Clinical Justification]. Alternative treatments including [List Alternatives Tried] have been exhausted or are contraindicated.

Peer-to-Peer Discussion Points:
During our discussion, the following points were addressed:
- [Point 1 discussed]
- [Point 2 discussed]
- [Response to specific denial criteria]

Based on the clinical evidence and the additional context provided during our call, I am formally requesting a reversal of the previous denial and immediate authorization for the requested services.

Please provide a written determination regarding this authorization request via fax to [Fax Number] or phone at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice/Facility Name]
[NPI Number]