URGENT MEDICAL NECESSITY AUTHORIZATION REQUEST AND PEER-TO-PEER SUMMARY

Date: [Insert Date]
To: [Insurance Company Name] - Utilization Management Department
Fax: [Insert Fax Number]
Reference Number: [Insert Prior Authorization Number or Denied Claim ID]

PATIENT INFORMATION:

- **Patient Name:** [Patient Name]
- **Date of Birth:** [DOB]
- **Member ID:** [Member ID]
- **Policy Group:** [Group Number]

PROVIDER INFORMATION:

- **Requesting Physician:** [Physician Name]
- **NPI Number:** [NPI Number]
- **Contact Person:** [Name and Title]
- **Direct Phone/Extension:** [Phone Number]

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1. URGENT CLINICAL SUMMARY

Diagnosis: [Insert ICD-10 Code and Description]
Proposed Treatment/Procedure: [Insert CPT/HCPCS Code and Description]
Clinical Urgency: [Describe why standard review timeframes will jeopardize the patient's health or life].

2. RATIONALE FOR MEDICAL NECESSITY

The requested service is medically necessary based on the following clinical data:
[Summarize patient history, failed previous treatments, relevant lab results, and imaging findings].

3. PEER-TO-PEER REVIEW REQUEST

In the event of a potential denial, the requesting physician, **[Physician Name]**, requests a formal Peer-to-Peer review with a Medical Director of the same or similar specialty.

Preferred Availability for Peer-to-Peer:
[Date 1] between [Time Range]
[Date 2] between [Time Range]

4. ATTACHMENTS

- Clinical Notes dated [Date Range]
- Diagnostic Imaging/Lab Reports
- Relevant Medical Guidelines (e.g., NCCN, Milliman, etc.)

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[Facility Name]