Date: [Date]

To: [Insurance Company Name] / Utilization Review Department

Fax/Email: [Fax Number/Email Address]

Subject: Urgent Authorization Request for Surgical Procedure

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Provider Name: [Surgeon Name]

Facility: [Hospital/Surgical Center Name]

Proposed Procedure: [Procedure Name and CPT Code]

ICD-10 Diagnosis: [Diagnosis Code]

Dear Medical Director,

I am writing to request formal authorization for the surgical procedure listed above. Based on the patient's clinical presentation and the failure of conservative management, this surgery is medically necessary to prevent further functional decline.

Clinical Justification:

- **Diagnosis:** [Briefly describe the condition].
- **Failed Conservative Treatments:** [List medications, physical therapy, or injections tried].
- **Clinical Findings:** [List relevant MRI, X-ray, or physical exam results].

Please provide a determination by [Date]. If you require further documentation, please contact our office at [Phone Number].

Sincerely,

[Surgeon Signature]
[Surgeon Name and Title]

Subject: Peer-to-Peer Discussion Outcome Summary

Reference/Reference Number: [Auth Reference Number]

Date of Discussion: [Date]

Reviewing Medical Director: [Name of Insurance Physician]

Following the Peer-to-Peer discussion held on [Date], this letter serves to summarize the clinical consensus reached regarding the proposed treatment for [Patient Name].

Outcome Status: [Approved / Denied / Partially Approved]

Key Discussion Points:

- The Medical Director reviewed the additional clinical data regarding [Specific Clinical Detail].
- Agreement was reached that the patient meets [Milliman/InterQual] criteria for [Procedure Name].
- [Optional: Specific limitations or requirements discussed during the call].

Action Taken:

[Example: The initial denial has been overturned. The authorization number is [Auth Number].]

Best regards,

[Your Name/Title]
[Organization Name]