Date: [Insert Date]

TO: Medical Director / Review Department
Organization: [Insurance Company Name]
Fax/Email: [Insert Fax Number or Email Address]

RE: Peer-to-Peer Review Summary and Authorization Request
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Member ID Number]
Reference/Case Number: [Insert Reference Number]

Dear Medical Director,

This letter serves as a formal summary of the peer-to-peer discussion held on [Date] between [Requesting Physician Name] and [Insurance Reviewer Name] regarding the requested specialist consultation/procedure for the aforementioned patient.

Clinical Justification:
The patient presents with [Diagnosis/Symptoms]. Current conservative treatments, including [List Previous Treatments/Medications], have been exhausted without adequate improvement. Specialist intervention is necessary to [State Goal: e.g., prevent further deterioration, perform diagnostic biopsy, manage complex symptoms].

Summary of Discussion:
During our discussion, we addressed the following points:

- The medical necessity of [Requested Service/Consultation].
- How the patient meets clinical criteria for [Relevant Guideline/Policy].
- [Insert specific clinical data or literature discussed during the call].

Requested Action:
Based on the clinical evidence and our verbal consultation, I am requesting an immediate reversal of the prior denial and full authorization for:
Service: [Insert Specific Specialist Service/Procedure Code]
Provider: [Specialist Name/Facility]

If further information is required, please contact my office at [Phone Number]. Thank you for your prompt attention to this matter.

Sincerely,

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