Date: [Date]

To: [Medical Director Name/Utilization Review Department]
Health Plan: [Insurance Company Name]
Fax Number: [Fax Number]

RE: Urgent Request for Authorization for Advanced Therapeutic Intervention

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

Dear Medical Director,

This letter summarizes the Peer-to-Peer discussion held on [Date] between [Requesting Provider Name] and [Health Plan Medical Director Name] regarding the requested [Name of Procedure/Intervention].

Clinical Justification Summary:
The patient presents with [Diagnosis/ICD-10 Code]. Current standard treatments, including [List previous failed treatments/medications], have proven ineffective or are contraindicated because [Reason]. The requested advanced intervention is medically necessary because [Clinical rationale/Expected outcome].

Peer-to-Peer Discussion Outcome:
During our discussion, it was acknowledged that:
- [Point 1: e.g., The patient's condition is deteriorating.]
- [Point 2: e.g., Clinical data supports the use of this intervention for this specific case.]
- [Point 3: e.g., Alternative therapies have been exhausted.]

Requested Action:
Based on the clinical evidence provided and our verbal consultation, I am requesting an immediate formal authorization for [Procedure/Service Code]. Delay in this intervention poses a significant risk to the patient's health, including [List potential risks].

Please provide written confirmation of this authorization via fax to [Fax Number] within [Number] hours.

Sincerely,

[Physician Signature]
[Physician Name, Title]

[Facility Name]
[Phone Number]