Date: [Date]

To: [Health Insurance Company Name]
Attn: Utilization Management / Medical Review Department
Fax/Email: [Fax Number or Email Address]

RE: REQUEST FOR PEER-TO-PEER REVIEW AND OUT-OF-NETWORK AUTHORIZATION

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

Dear Medical Director,

I am writing to formally request a Peer-to-Peer review regarding the denial of coverage for out-of-network services for the above-referenced patient. We are seeking authorization for services to be provided by [Provider Name/Facility Name], located at [Address].

Requested Services/Procedure: [Name of Procedure/Treatment and CPT Codes]

Clinical Justification Summary:
The patient requires specialized care for [Diagnosis/Condition]. Treatment at this out-of-network facility is medically necessary because:

- [Reason 1: e.g., Lack of in-network providers with this specific expertise]
- [Reason 2: e.g., Continuity of care requirements]
- [Reason 3: e.g., Geographic proximity for urgent/ongoing monitoring]

Peer-to-Peer Contact Information:
The treating physician, [Requesting Physician Name], is available to discuss this case with a physician reviewer of the same or similar specialty.

Primary Contact Number: [Direct Phone Number]
Best Times for Callback: [List 2-3 Time Slots and Time Zone]

We request that this review be completed urgently to avoid any delay in the patient's necessary medical treatment. Please contact our office at [Office Phone Number] to confirm the scheduled time for the Peer-to-Peer discussion.

Sincerely,

[Physician Signature]
[Physician Name, Title]

[Practice/Facility Name]
[Phone Number]