DATE: [Date]

TO: [Health Plan Name]
ATTENTION: Utilization Management / Medical Director
FAX/EMAIL: [Fax Number/Email Address]

RE: Inpatient Admission Peer-to-Peer Review Summary and Authorization Request

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

FACILITY INFORMATION:
Admitting Facility: [Facility Name]
Date of Admission: [Admission Date]
Attending Physician: [Physician Name]

PEER-TO-PEER REVIEW SUMMARY

On [Date of Call], a Peer-to-Peer review was conducted between [Treating Physician Name/Title] and [Health Plan Medical Director Name].

Clinical Justification for Inpatient Status:
The patient presented with [Primary Diagnosis/Symptoms]. Based on clinical judgment and Milliman Care Guidelines (MCG) or InterQual criteria, acute inpatient level of care is required due to:
- [Reason 1: e.g., Severity of illness]
- [Reason 2: e.g., Failure of outpatient/observation management]
- [Reason 3: e.g., Requirement for frequent monitoring/IV interventions]

Treatment Plan:
The patient is currently receiving [Specific Treatments/Procedures]. Expected length of stay is [Number] days. Discharge is contingent upon [Discharge Criteria].

Outcome of Discussion:
[Select one: The Medical Director verbally overturned the initial denial / The Medical Director maintained the denial but requested additional documentation / Awaiting final determination].

FORMAL REQUEST FOR AUTHORIZATION

Based on the clinical evidence provided during the Peer-to-Peer review, we formally request authorization for the inpatient stay from [Start Date] to [End Date/Discharge]. Failure to authorize this level of care may result in [Potential Clinical Risks].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]
[Your Title]
[Organization Name]
[Phone Number]