URGENT PRIOR AUTHORIZATION REQUEST

Date: [Insert Date]

TO: [Insurance Company Name]
Attn: Prior Authorization Department / Medical Review
Fax Number: [Insert Fax Number]

RE: Patient Information
Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Member ID: [Insert Member ID]
Group Number: [Insert Group Number]
Case/Reference Number: [If applicable]

Provider Information
Requesting Provider: [Physician Name]
NPI Number: [Insert NPI]
Phone: [Insert Phone Number]
Fax: [Insert Fax Number]

Clinical Information
Requested Test: [Name of Genetic Test]
CPT Codes: [Insert CPT Codes, e.g., 81401]
Laboratory: [Name of Performing Lab]
ICD-10 Diagnosis Codes: [Insert Diagnosis Codes]

To Whom It May Concern,

I am writing to request an **urgent** prior authorization for diagnostic genetic testing for the patient listed above. This request is marked as urgent because a delay in testing would significantly jeopardize the patient's life, health, or ability to regain maximum function, or would subject the patient to severe pain that cannot be adequately managed without the results of this test.

Clinical Justification:
The patient presents with [List symptoms or family history]. Based on the clinical presentation, this specific genetic test is medically necessary to [select one: establish a diagnosis / determine immediate surgical intervention / guide urgent pharmacological treatment].

Previous Evaluation:
[Briefly list previous tests, imaging, or failed treatments that justify the move to genetic testing].

Attached please find the clinical notes, pedigree, and laboratory requisition form supporting this request. We request an expedited review and a determination within [Insert Timeframe, e.g., 24-72 hours].

Please contact my office at [Insert Phone Number] if further information is required.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Practice Name]