URGENT / EXPEDITED PRIOR AUTHORIZATION REQUEST

Date: [Insert Date]

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

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

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

Requested Procedure: [Insert Specific Injection Type, e.g., Lumbar Epidural Steroid Injection]
CPT Code(s): [Insert Codes]
ICD-10 Diagnosis Code(s): [Insert Diagnosis Codes]

Urgency Statement:
I am requesting an **expedited review** of this authorization. A standard 72-hour or 14-day turnaround time would seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. The patient is currently experiencing intractable pain that is unresponsive to conservative management, resulting in [Functional Deficit, e.g., inability to walk, risk of ER visit].

Clinical Justification:
The patient has been diagnosed with [Insert Diagnosis]. Symptoms have persisted for [Duration]. The following conservative treatments have been attempted and failed:
- Physical Therapy: [Dates/Results]
- Medications (NSAIDs, Gabapentinoids, etc.): [Names/Results]
- Previous Injections: [Dates/Results]

Current physical examination findings include: [Insert Key Findings, e.g., positive straight leg raise, focal weakness]. Imaging (MRI/CT) dated [Date] confirms [Insert Finding, e.g., herniated disc at L4-L5].

Failure to provide this intervention immediately will likely result in [ER Admission/Loss of Mobility/Permanent Nerve Damage].

Please provide a determination via fax within 24 hours.

Sincerely,

[Physician Signature]
[Physician Printed Name]