Date: [Date]
To: [Insurance Company Name]
Department: Prior Authorization / Appeals Department
Fax/Address: [Fax Number or Address]

RE: Retroactive Prior Authorization Request for Emergency Services

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Date of Service: [Date Treatment was Provided]
Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

This letter is a formal request for a retroactive prior authorization for emergency pain management injections administered to the above-referenced patient on [Date of Service].

Clinical Justification:
The patient presented with [Description of Acute Condition, e.g., severe acute spinal pain, traumatic injury]. The severity of the pain was rated at [Pain Scale Score] and was accompanied by [Symptoms, e.g., loss of mobility, neurological deficits].

Immediate intervention was medically necessary to stabilize the patient and prevent further physiological distress or emergency department admission. Due to the acute and emergent nature of the patient's condition, the [Type of Injection, e.g., Trigger Point Injection, Epidural Steroid Injection] was performed immediately. Obtaining prior authorization was not feasible as it would have resulted in an unsafe delay of necessary medical care.

Procedure Details:
CPT Code(s): [Insert CPT Codes]
Diagnosis Code(s): [Insert ICD-10 Codes]

Attached you will find the clinical notes, physical examination findings, and the procedure report documenting the medical necessity and the emergent circumstances of this treatment.

Please process this retroactive authorization to ensure the claim is paid. If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Name]
[Practice Name]
[NPI Number]
[Phone Number]