URGENT PRIOR AUTHORIZATION REQUEST: EXPEDITED REVIEW REQUESTED

Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department
Fax Number: [Fax Number]

RE: Patient Information
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy ID: [Member ID]
Group Number: [Group Number]

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

Clinical Information
Diagnosis: Suspected Severe Obstructive Sleep Apnea (ICD-10: G47.33)
Requested Procedure: [Polysomnography / Home Sleep Apnea Test]
CPT Code(s): [Insert CPT Code, e.g., 95810 or 95806]

To Whom It May Concern,

I am writing to request an **expedited prior authorization** for diagnostic sleep testing for the above-referenced patient. This request is urgent due to the severity of the patient's symptoms and the high risk of life-threatening comorbidities.

The patient currently presents with the following clinical indications:

- Epworth Sleepiness Scale Score: [Score]
- Observed apnea/gasping during sleep
- Oxygen desaturations noted during [Pulse Oximetry/Screening]
- Comorbidities: [e.g., Hypertension, Atrial Fibrillation, Type 2 Diabetes]

The patient's condition significantly impairs their daily functioning and presents an immediate risk for cardiovascular events. A delay in diagnosis and subsequent treatment would jeopardize the patient's health and safety.

Please find attached clinical notes, physical examination results, and relevant screening tools supporting this request. We look forward to your immediate response.

Sincerely,

[Physician Signature]
[Physician Printed Name]