[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Retroactive Authorization Appeal
Patient Name: [Patient Name]
Member ID: [Member ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

To the Appeals Department,

I am writing to formally appeal the denial of coverage for the services provided on [Date of Service] at [Facility/Provider Name]. The claim was denied due to a lack of prior authorization.

I am requesting a retroactive authorization for these services based on the following circumstances: [Insert reason here, e.g., medical emergency, urgent clinical need, administrative oversight, or late notification of insurance coverage].

The services provided were medically necessary because: [Briefly describe the medical necessity or refer to attached doctor's notes].

Enclosed, please find supporting documentation, including:

- Medical records from the date of service
- A letter of medical necessity from my physician
- [Any other relevant documents]

I kindly request that you review this appeal and grant a retroactive authorization so that the claim may be reprocessed for payment. Thank you for your time and reconsideration of this matter.

Sincerely,

[Your Signature]

[Your Printed Name]