

URGENT: EXPEDITED APPEAL REQUEST
ATTENTION: MEDICAL REVIEW DEPARTMENT / APPEALS UNIT

Date: [Date]

RE: Expedited Appeal for Inpatient Stay Denial

Patient Name: [Patient Name]

Member ID: [Member ID Number]

Date of Birth: [DOB]

Reference/Authorization Number: [Reference Number]

Facility Name: [Hospital Name]

Date of Admission: [Admission Date]

To Whom It May Concern,

This letter is a formal request for an **expedited urgent appeal** regarding the denial of the inpatient length of stay for the above-mentioned patient. I am appealing this decision because a discharge at this time would pose a serious threat to the patient's health and safety.

Clinical Justification:

The patient continues to require acute inpatient hospital care based on the following clinical indicators:

- Current Vital Signs and Stability: [Enter details]
- Required Treatments/Interventions: [Enter specific treatments requiring hospital setting]
- Risk of Discharge: [Enter potential complications if discharged]
- Physician Assessment: [Enter doctor's recommendations]

According to the patient's medical records and current status, they do not meet the criteria for discharge to a lower level of care. Delaying this appeal through the standard process could result in significant clinical decline.

Please review this expedited request immediately and provide a determination within [24/72] hours as required by regulatory guidelines. Please contact the undersigned at [Phone Number] for any further information or to coordinate a Peer-to-Peer review.

Sincerely,

[Your Name/Signature]

[Title/Relationship to Patient]

[Phone Number]

[Email Address]