URGENT: EXPEDITED APPEAL REQUESTED
Clinical Condition: [Insert Diagnosis]
Proposed Procedure: [Insert Name of Surgery]

[Date]

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

RE:
Patient Name: [Patient Full Name]
Member ID: [ID Number]
Group Number: [Group Number]
Reference/Authorization Number: [Reference Number from Denial]

To Whom It May Concern,

This is a formal request for an **expedited appeal** regarding the denial of coverage for [Name of Surgery]. I am requesting an immediate review of this decision, as a standard appeal timeframe would seriously jeopardize the patient's life, health, or ability to regain maximum function.

Medical Necessity and Urgency:
The patient is suffering from [Detailed Diagnosis]. Surgical intervention is required immediately because [Explain why surgery is urgent, e.g., risk of permanent nerve damage, organ failure, or debilitating pain]. Delaying this procedure will result in [List specific clinical risks or complications].

Reason for Appeal:
We disagree with the denial stating [Insert Reason Given in Denial Letter, e.g., "Not Medically Necessary"]. Based on [Insert Guidelines, e.g., Milliman Care Guidelines or Peer-Reviewed Research], this procedure is the standard of care for this condition because [Explain logic].

Enclosed Documentation:

- Letter of Medical Necessity from Dr. [Surgeon's Name]
- Relevant Imaging Results (MRI/CT/X-Ray)
- Recent Clinical Notes and Physical Examination Findings
- Failed Conservative Treatments (if applicable)

Due to the acute nature of this condition, we request a determination within 72 hours. Please contact my office immediately at [Phone Number] or [Email Address] with your decision or if further information is required.

Sincerely,

[Signature]
[Printed Name of Physician/Patient]
[Title/Relationship to Patient]
[Contact Information]