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

[Date]

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

RE: Urgent Appeal for Retroactive Authorization

Patient Name: [Patient Full Name]
Member ID Number: [ID Number]
Claim/Reference Number: [Claim Number]
Date of Service: [Date of Visit]
Specialist Name: [Provider Name]

To the Appeals Committee,

I am writing to formally appeal the denial of coverage for the specialist visit that occurred on [Date of Service]. This request is for a retroactive authorization due to the urgent medical necessity of the consultation.

The referral was not obtained prior to the visit because [Reason: e.g., the appointment was an emergency, the next available opening was immediate and required to prevent health deterioration, or provider availability]. Delaying the visit to wait for administrative processing would have resulted in [Explain medical risk or worsening symptoms].

Attached is a letter from my primary care physician, [PCP Name], supporting the urgency of this referral and detailing the medical necessity of the treatment provided by [Specialist Name].

I request that you review the clinical urgency of this case and grant a retroactive authorization to cover the costs of this essential care. Please notify me of your decision within [Number] days.

Thank you for your time and reconsideration.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures:
- Letter of Medical Necessity from PCP
- Specialist Consultation Notes
- Copy of Denial Letter