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

[Date]

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

RE: Appeal for Retroactive Authorization
Patient Name: [Patient Full Name]
Member ID: [Insurance ID Number]
Claim Number: [Claim Number, if applicable]
Date of Service: [Date of Procedure]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Procedure/Service] performed on [Date] by [Physician Name] at [Facility Name]. This request is for a retroactive authorization due to unforeseen clinical complications that occurred during the scheduled procedure.

The original authorized procedure was [Original Procedure Name]. However, during the course of this treatment, the following medical complication arose: [Briefly describe the complication, e.g., unexpected hemorrhage, discovery of additional pathology, or acute physiological distress].

Due to the immediate and life-threatening nature of these complications, it was medically necessary for the surgical team to perform [Name of Additional/New Procedure] immediately. This intervention was required to ensure patient safety and stabilization. Because this was an emergent intraoperative decision, obtaining prior authorization was not possible at the time of the event.

Attached to this letter, please find the following supporting documentation:

- Operative reports detailing the unforeseen complications.
- Clinical notes from the attending physician justifying the necessity of the additional procedure.
- Discharge summary and relevant lab results.

I request that you review this case in light of the medical necessity and the emergency circumstances described. If you require any further information, please contact me at [Phone Number] or [Provider Office Contact].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Relationship to Patient]