

PRIOR AUTHORIZATION — PATIENT GUIDE

What it is, why you need it, and what happens if you skip it

What Is Prior Authorization?

Prior authorization (also called prior auth, pre-authorization, or pre-approval) is a process where your insurance company must give their written approval BEFORE you receive certain medical services, tests, procedures, or medications.

Think of it like a permission slip. Your doctor says you need a specific treatment. Before they can provide it, they must ask your insurance company for permission. The insurance company then decides whether they will cover the cost of that treatment under your plan.

Why Do Insurance Companies Require It?

Insurance companies use prior authorization to make sure that expensive or specialized services are truly necessary before they agree to pay for them. While this process can feel like a hurdle, understanding it can help you avoid unexpected medical bills.

■ **Important:** If you receive a service that requires prior authorization and your insurance has NOT approved it ahead of time, your insurance company may refuse to pay — leaving you responsible for the full cost.

What Types of Services Usually Need Prior Authorization?

Not every visit or service requires prior auth. Here are the most common ones that do:

Specialist Referrals	Visits to specialists like cardiologists, neurologists, or orthopedic surgeons often require your primary care doctor to send a referral and get prior auth from your insurance.
Surgeries and Procedures	Most planned (non-emergency) surgeries, as well as procedures like colonoscopies, biopsies, or joint injections, often require prior auth.
Imaging Tests	Advanced scans such as MRI, CT scan, PET scan, and some ultrasounds frequently require prior authorization.
Specialty Medications	Brand-name drugs, biologics, specialty medications, and some expensive generics often need approval before your pharmacy can fill them.
Mental Health Services	Inpatient psychiatric care, intensive outpatient therapy, and some counseling services may need prior authorization.
Durable Medical Equipment	Wheelchairs, walkers, CPAP machines, braces, and other equipment often require approval.
Physical / Occupational Therapy	Ongoing therapy sessions beyond a certain number often require a new authorization.

Home Health Services	Skilled nursing care or therapy at home after a hospital stay usually needs prior auth.
-----------------------------	---

How Does the Prior Authorization Process Work?

Here is the typical step-by-step process from start to finish:

Step 1	Your Doctor Recommends a Service Your doctor decides you need a specific treatment, test, medication, or specialist visit. They document this in your medical chart.
Step 2	Our Office Submits a Request We contact your insurance company and submit a Prior Authorization Request. This includes your doctor's clinical notes, diagnosis codes, and the reason the service is medically necessary.
Step 3	Insurance Reviews the Request Your insurance company reviews the request. They compare it to their coverage guidelines. This usually takes 3 to 15 business days for a standard request. Urgent requests may be reviewed within 24–72 hours.
Step 4	Insurance Issues a Decision Your insurance company will either: (a) Approve the request — the service is covered; (b) Deny the request — they don't think it's necessary; or (c) Request more information — they need additional medical records or documentation.
Step 5	We Notify You We will contact you with the decision. If it is approved, we will schedule your service. If it is denied, we will explain your options, including your right to appeal.

How Long Does Prior Authorization Take?

Request Type	Typical Timeframe	When to Use
Standard / Routine	3–15 business days	Planned procedures, non-urgent specialist visits, regular medications
Urgent / Expedited	24–72 hours	When your doctor believes your health would seriously decline without faster approval
Emergency	Retroactive review	Emergency services do not require prior auth beforehand — insurance reviews the claim after the fact

What If My Prior Authorization Is Denied?

A denial does NOT have to be the end of the road. You have the right to appeal any insurance decision. Here is what you can do:

✓ Ask Us to File a Peer-to-Peer Review	Your doctor can personally speak with the insurance company's medical reviewer to explain why the service is necessary. This resolves many denials quickly.
✓ Submit Additional Medical Records	Sometimes a denial happens because the insurance company did not have enough information. We can send additional documentation to support your case.
✓ File a Formal Appeal	You have the legal right to formally appeal any denied claim. Deadlines typically range from 30 to 60 days after the denial date.
✓ Request an Expedited Appeal	If your health is at risk from delays, you can request a faster appeal process.
✓ External Review	If all internal appeals fail, you can request an external review by an independent organization — not your insurance company.

Your Prior Authorization Checklist

When your doctor recommends a service that may need prior auth, here is what you should do:

- Ask our front desk or billing team if your service requires prior authorization.
- Make sure we have your most up-to-date insurance card on file.
- Do NOT schedule the service or fill a specialty prescription until you have confirmed authorization.
- Keep a record of any authorization number you receive — you will need this at your appointment.
- If you change insurance plans, let us know immediately — your old authorization may no longer be valid.
- Always confirm with your insurance directly if you are unsure about coverage.

■ **Did You Know?** Prior authorizations are not permanent. Most approvals are valid for only 60 to 90 days. If your appointment is delayed or rescheduled past the authorization expiration date, we will need to request a new one. Please contact us as soon as you know about any scheduling changes.

Questions? Our Team Is Ready to Help

Prior authorization can be complicated — but you don't have to figure it out alone. Our billing and authorization team handles prior auths every day and will guide you through every step.

■ Call (555) 222-4400 Mon–Fri, 8 AM–5 PM	✉ Email billing@suncaremedical.com Response within 1 business day	■ Patient Portal www.suncaremedical.com Check auth status 24/7
--	---	--