

Prior Authorization Checklist

Complete every step BEFORE the patient's service to avoid claim denial

Prior Authorization (Prior Auth) means getting the insurance company's approval BEFORE a patient receives a service. If you skip this step, the claim may be denied and your practice won't get paid. Use this checklist for every service that requires approval.

STEP 1 – Patient & Insurance Verification

- **Confirm patient's full legal name and date of birth ★**
Match exactly with the insurance ID card. Even a small spelling error can cause a denial.
■ *Tip: Always ask the patient to spell their name aloud.*
 - **Verify insurance is active today**
Call the payer or check their online portal. Do not rely on last visit's information — coverage changes often.
■ *Tip: Write down the rep's name and reference number when you call.*
 - **Check if the patient has a secondary insurance**
If yes, note which insurance is primary and which is secondary. Both may have different auth requirements.
 - **Confirm the patient's group number, member ID, and plan name**
These are found on the insurance card. Some plans require the exact plan name for auth requests.
- *Always verify insurance on the DAY OF service, not just when scheduling. Coverage can change overnight.*

STEP 2 – Service & Medical Necessity Check

- **Get the exact CPT code(s) for the planned service ★**
CPT codes are the standard billing codes for medical procedures. The auth must be requested for the correct code(s).
- **Confirm the diagnosis code (ICD-10) that justifies the service**
The insurance will ask WHY this service is needed. The ICD-10 code is the medical reason. Make sure it matches the physician's documentation.
- **Check the payer's medical policy / coverage criteria**
Each insurance has rules about when they will cover a service. Read their policy to make sure this patient qualifies.
■ *Tip: Search the payer's website for their 'Clinical Policy Bulletins' or 'Coverage Guidelines'.*
- **Confirm if a referral from a primary care doctor is also needed**
HMO plans often require a referral in addition to prior auth. Check both requirements separately.

STEP 3 – Submitting the Auth Request

**Submit auth request via the payer's preferred method ★**

This could be online portal, fax, or phone. Check the payer's website for their preferred method — using the wrong method causes delays.

**Include all supporting clinical documents**

This typically includes: physician's notes, lab results, imaging reports, and a letter of medical necessity. Missing documents = delays or denial.

**Note the auth submission date and expected decision timeline**

Routine auth: 3–5 business days. Urgent/expedited: 24–72 hours. Keep a follow-up reminder.

**Record the auth tracking/reference number**

Every submission gets a tracking number. Save it immediately — you'll need it if there are questions later.

■ *Tip: Enter this number into your practice management system right away.*

■ *Urgent / emergency services may not need prior auth. But always document why the service was urgent.*

STEP 4 – After Approval

**Save the official authorization number ★**

This number MUST appear on the claim. Without it, the claim will be denied even if the auth was approved.

**Check the approved date range**

Auth is only valid for specific dates. If the service happens outside those dates, you need a new auth.

**Verify the approved number of visits or units**

For example, physical therapy might be approved for 10 visits only. Billing beyond what was approved will be denied.

**Notify the patient and the treating provider**

Let them know the auth is approved, what was approved, and any limitations.

**Attach auth number to the patient's account and upcoming appointment**

This ensures the billing team can find it easily when submitting the claim.

Completed by:

Date: _____

Supervisor: _____