Prior Auth Cheat Sheet

One-page quick reference for the front desk | ClinicOps

1 BEFORE YOU SUBMIT (every request)

1. Does this service need prior auth for **this patient's plan**? Confirm before they leave.
2. Eligibility verified: plan active, service covered, plan and group numbers exact.
3. Documentation the payer's reviewer wants is attached (not just what you assume proves necessity).
4. Codes checked: CPT or HCPCS and ICD-10 support each other.
5. Right submission channel identified for this payer.

2 SUBMIT

Send via the payer's channel: **Portal / Fax / Phone**. Always capture the **confirmation number** and log it. Set a follow-up date the same minute.

3 FOLLOW-UP CADENCE (never let it sit)

48 hours → confirm received. **5 days** → confirm in review. **10 days** → push on the payer's decision deadline.

Many plans must decide urgent requests within 72 hours, standard within 7 days. Know the clock and hold them to it.

4 ON APPROVAL (the step everyone forgets)

Record the **auth number** AND the **expiration date**, and set an **alarm**. An approval that expires before the visit voids the claim.

5 IF DENIED

1. Log the denial with the payer's stated reason.
2. Fix data or coding, or request a peer-to-peer review where it applies.
3. Appeal with your standard packet. Denials are often overturned, but only if you appeal.

THE ONE RULE

Chart numbers only. Never put a patient name, date of birth, or diagnosis in a tracker or board. The board holds the workflow; your EHR holds the patient.