

Authorization Call Script

Step-by-step phone script for requesting prior authorizations from insurance payers

Use this script every time you call a payer for prior authorization. Fill in the Before You Call section before dialing. Document every response immediately — do not rely on memory.

BEFORE YOU CALL — GATHER THIS FIRST

Patient Name:	<i>[Last, First]</i>
Date of Birth:	<i>[MM/DD/YYYY]</i>
Member / Policy ID:	<i>[Member ID]</i>
Group Number:	<i>[Group Number]</i>
Payer Name:	<i>[Insurance Company]</i>
Provider Line Phone:	<i>[Phone Number]</i>
Requesting Provider:	<i>[Name, NPI]</i>
Rendering Provider (if diff.):	<i>[Name, NPI]</i>
CPT Code(s) Requesting Auth For:	<i>[Code(s)]</i>
ICD-10 Diagnosis:	<i>[Code(s)]</i>
Requested Service Date:	<i>[MM/DD/YYYY]</i>
Place of Service:	<i>[Code / Setting]</i>
Units / Visits Requested:	<i>[#]</i>
Urgency:	<i>[] Routine [] Urgent [] Emergent</i>

Clinical documentation ready to fax/upload:

- Letter of medical necessity
- Relevant clinical notes / H&P
- Prior treatment history
- Supporting lab, imaging, or diagnostic results

THE CALL SCRIPT

1 Navigate the IVR / Get to the Right Department

Call the Provider Services / Prior Authorization line on the back of the member's insurance card. Listen carefully to menu options — you typically want: Prior Authorization or Utilization Management. Avoid the Member Services line.

"Press [#] for Prior Authorization. If unsure, say 'Prior Authorization' to the automated system."

2 Verify Your Identity as a Provider

The rep will ask for your NPI, Tax ID, and practice information before giving you any claim-specific information.

Hold Time:	<hr/> <i>[# minutes]</i> <hr/>
Auth Required?	<hr/> <i>[] Yes [] No [] Not Confirmed</i> <hr/>
Auth Number:	<hr/> <i>[Auth # or Pending]</i> <hr/>
Decision:	<hr/> <i>[] Approved [] Denied [] Pended [] Needs Documentation</i> <hr/>
Approved Dates:	<hr/> <i>[MM/DD/YYYY] through [MM/DD/YYYY]</i> <hr/>
Approved Units:	<hr/> <i>[#]</i> <hr/>
Fax Required?	<hr/> <i>[] Yes — Fax to: [Fax #] [] No</i> <hr/>
Fax Confirmation #:	<hr/> <i>[Confirmation #]</i> <hr/>
Expected Decision Date (if pended):	<hr/> <i>[MM/DD/YYYY]</i> <hr/>
Follow-Up Date:	<hr/> <i>[MM/DD/YYYY]</i> <hr/>
Additional Notes:	<hr/> <i>[Any conditions, restrictions, or payer-specific requirements communicated on the call]</i> <hr/>

IF THE AUTHORIZATION IS DENIED ON THE CALL

- Ask for the specific denial reason and denial code
- Ask what clinical documentation would support a reconsideration
- Request a peer-to-peer review with the medical director *available within 72 hours at most payers*
- Ask for the appeal deadline and fax number for appeal submissions
- Document denial reason, rep name, and reference number
- Notify the ordering provider same day — do not schedule service until auth is resolved

Denial Reason Given:	<hr/> <i>[Denial reason / code]</i> <hr/>
Peer-to-Peer Requested?	<hr/> <i>[] Yes — Scheduled: [Date/Time] [] No</i> <hr/>
Appeal Deadline:	<hr/> <i>[MM/DD/YYYY]</i> <hr/>