

# Prior Authorization Request Checklist

Gather all required information before submitting a prior authorization request to avoid delays

Complete this checklist before calling, faxing, or submitting a PA request online. Missing information is the leading cause of PA delays and denials.

## PATIENT & INSURANCE INFORMATION

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**Patient Name:**  [Last, First, Middle Initial]

**Date of Birth:**  [MM/DD/YYYY]

**Member / Policy ID:**  [Member ID]

**Group Number:**  [Group Number]

**Insurance Company:**  [Payer Name]

**Insurance Phone (Provider Line):**  [Phone Number]

**Plan Type:**  HMO  PPO  EPO  HDHP  Medicaid  Medicare Advantage

**Effective Date:**  [MM/DD/YYYY] Termination Date:  [MM/DD/YYYY or Active]

## PROVIDER INFORMATION

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**Requesting Provider:**  [Name, Credentials]

**Requesting NPI:**  [NPI Number]

**Requesting Provider Phone:**  [Phone] Fax:  [Fax]

**Rendering / Performing Provider:**  [Name — if different from requesting]

**Rendering NPI:**  [NPI Number]

**Facility / Practice Name:**  [Facility Name]

**Facility NPI:**  [NPI Number]

**Referring Provider (if applicable):**  [Name and NPI]

## SERVICE BEING REQUESTED

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**CPT / HCPCS Code(s):**  [Code(s) — list all requiring auth]

**Description of Service:**  [Plain-English description of procedure/service]

**ICD-10 Diagnosis Code(s):**  [Primary dx in A; supporting codes in B–D]

**Place of Service:**  Office (11)  Outpatient (22)  Inpatient (21)  Other:

**Requested Start Date:**  [MM/DD/YYYY]

**Requested End Date /**  [MM/DD/YYYY or # of visits/units]

**Duration:** \_\_\_\_\_  
**Units / Visits Requested:** *[Number]*  
**Urgency:** *[ ] Routine [ ] Urgent [ ] Emergent*

### CLINICAL DOCUMENTATION CHECKLIST

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*Most payers require clinical documentation with the PA request. Gather the following before submitting:*

- Letter of medical necessity or clinical notes from the ordering provider
- Relevant history and physical (H&P) or office visit notes
- Prior treatment history (documenting conservative treatments tried and failed)
- Lab results, imaging reports, or diagnostic findings supporting the request
- Applicable clinical guidelines, LCD, or NCD supporting medical necessity
- Plan of care / treatment plan
- Referral documentation (if service requires referral from PCP)
- Any prior authorization number for related previous services

### SUBMISSION CHECKLIST

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- Verified that prior authorization IS required for this CPT code / plan combination
- Called or checked payer portal to confirm correct PA submission method
- Submission method confirmed: *[ ] Phone [ ] Fax [ ] Portal [ ] EDI 278*
- All clinical documentation organized and ready to submit
- Verified patient's eligibility is active for the requested date of service
- Confirmed correct payer — primary vs. secondary

### AFTER SUBMISSION — TRACKING

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**Date Submitted:** *[MM/DD/YYYY]*  
**Submission Method:** *[ ] Phone [ ] Fax [ ] Portal [ ] EDI 278*  
**PA / Reference Number:** *[Number assigned at submission]*  
**Rep Name (if called):** *[Rep Name]*  
**Expected Decision Date:** *[MM/DD/YYYY — typically 3–15 business days]*  
**Follow-Up Date if No Response:** *[MM/DD/YYYY]*  
**Decision Received:** *[ ] Approved [ ] Denied [ ] Pended [ ] Partial Date: \_\_\_\_\_*  
**Auth Number (if approved):** *[Authorization Number]*  
**Approved Dates:** *[MM/DD/YYYY] through [MM/DD/YYYY]*  
**Approved Units / Visits:** *[Number]*

