Prior authorization checklist

What to check and attach before a request is submitted

1. ELIGIBILITY AND BENEFITS

- [ ] Member is active on the date of service
- [ ] Plan type and benefit covers the requested service
- [ ] Service actually requires authorization under this plan
- [ ] Remaining annual limit and any sub-limit checked
- [ ] Waiting period or pre-existing condition restriction checked
- [ ] Correct provider network or direct-billing arrangement

2. CLINICAL INFORMATION

- [ ] Working diagnosis and diagnosis codes (for example ICD-10)
- [ ] Requested service, procedure or medicine, with codes where used
- [ ] Clinical notes supporting medical necessity
- [ ] Relevant test results and imaging reports
- [ ] Treatment already tried, and outcome, where criteria require it
- [ ] Planned setting (inpatient, day case, outpatient) and expected length of stay

3. COST AND ADMINISTRATION

- [ ] Itemised cost estimate from the provider
- [ ] Requesting clinician's name and contact
- [ ] Planned date of service
- [ ] Urgency stated correctly (urgent or standard)
- [ ] Correct submission channel (portal, email, fax or phone)

4. AFTER SUBMISSION

- [ ] Reference number recorded in the tracker
- [ ] Decision deadline noted and follow-up date set
- [ ] Requests for more information answered in one complete reply
- [ ] Decision recorded: approved, partly approved, pended or denied
- [ ] For a denial: reason read, gap fixed, resubmission or appeal prepared
- [ ] Extensions requested before the approved stay ends