



Insurance Pre-Authorization

Pre-authorization assures you and your provider that treatment has been deemed “medically necessary” under the terms of your health plan. Most HMO policies require pre-authorization to receive coverage on non-emergent care outside of standard healthcare provided by your primary care physician. PPO policies may require it for certain procedures or specialist. As the insured, it is your responsibility to understand when pre-authorization is needed. Check your specific policy, if you are unsure.

A pre-authorization, does NOT imply that the insurance company will be covering the entire cost. Your deductible and co-pays will likely still apply. However, without pre-authorization you run the risk of being responsible for a larger portion, if not the entire cost, yourself. If you require a relatively expensive treatment or procedure, and there are any questions about your coverage, it is always better to get pre-authorization before proceeding with care.

When Do I Need Pre-Authorization?

Typically there is something going on with your health that requires additional treatment or services. For example, this may involve being seen by a specialist, surgeon or additional visits to a chiropractor. Any of these instances MAY require pre-authorization. It is critical to understand your specific coverage. The need for pre-authorization is determined by your specific health plan.

Who Will Make The Request?

The provider should submit your information to your insurer and request pre-authorization. While the physician’s office will most likely make the request on your behalf, don’t be afraid to call the insurance company and verify the authorization is complete. If a doctor’s office forgets or lets it fall through the cracks – there is a chance you will be responsible for payment.

If I Need To Make The Request, What Information Should I Include?

Pre-authorization requests generally require substantial background information such as:

- Other less costly and/or less invasive treatments that have already been tried and their duration
- Past history of the health issue including the conditions surrounding its original manifestation
- Physical documentation, such as test results, images (x-rays, MRIs, ultrasounds, photos), etc.
- Other supporting information that solidifies the medical necessity for this visit, service or procedure.

Always check with your specific insurance plan to see what information they require. Remember they are looking to validate “medical necessity.”

The Response

Every insurance company follows their own timeline, but you and the physician should get the response in writing within a couple of weeks. Remember, if your specialist is not in your insurer’s network (out-of-network provider), you may be responsible for a larger portion of the cost than for a specialist who is in-network.

What To Do If You Get Denied?

Denials are common, but they are generally accompanied by a reason for the denial. View the denial as a request for additional information and don’t get discouraged. (See the “Denied Medical Claim” worksheet of the Field Guide.)

Managing Changes In Treatment

Changes in treatment can be an issue. For example, a treatment regimen for cancer that involves multiple drugs could be disallowed if even one of the drugs is changed and/or considered experimental. If there’s a change from what is initially authorized, be aware that pre-authorization can be revoked. Be sure to get authorization *in writing* from your insurer for any changes.