**Prior authorization**

A prior authorization is an approval you need to get from the health plan for some services or treatments before they occur. In-network providers will request any necessary prior authorization on your behalf. Out-of-network providers may not, in which case you will need to submit any needed requests for prior authorization. Emergency services do not require a prior authorization. See below for information about what services require prior authorization and how to submit a request should you need to do so.

Prior authorization is not a guarantee of coverage. Payment is based on eligibility and benefits at the time of service. If you or your provider fail to obtain a prior authorization when it is required, any claims for the services that require prior authorization may be denied.

**The prior authorization process**

Our clinical team of experts will review the prior authorization request to ensure it meets current evidence-based coverage guidelines. For services that do not involve urgent medical conditions, Providence will notify you or your provider of its decision within two business days after the prior authorization request is received. If additional information is needed to process the request, Providence will notify you and your provider. We allow 15 calendar days for you or your Provider to submit the additional information. Within two business days of the receipt of the additional information, Providence will complete its review and notify you and your Provider of its decision. If the information is not received within 15 calendar days, the request will be denied. A letter will be sent to you and your provider detailing the reason for the denial and explaining your appeal rights if you feel the denial was issued in error.

**Expedited prior authorization**

For services that involve urgent medical conditions: Providence will notify your provider or you of its decision within 72 hours after the prior authorization request is received. If Providence needs additional information to complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Providence will complete its review and notify the requesting provider or you of its decision by the earlier of (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.

**Authorizations involving concurrent care decisions**

Providence will notify you if an approved ongoing course of treatment is reduced or ended because of a medical cost management decision. You may submit a request to reconsider that decision at least 24 hours before the course of treatment is scheduled to end. Providence will then notify you of its reconsideration decision within 24 hours after your request is received. You can make this request by either calling customer service or by writing the medical management team.

**Services requiring prior authorization**

Below is a short list of commonly requested services that require a prior authorization. This is not a complete list. For a complete list of services and treatments that require a prior authorization click here. We recommend you consult your provider when interpreting the detailed prior authorization list.

- All inpatient hospital admissions (not including emergency room care)
    - In an emergency situation, go directly to a hospital emergency room. You do not need Prior Authorization for emergency treatment; however, we must be notified within 48 hours following the onset of inpatient hospital admission or as soon as reasonably possible.
- All hospital and birthing center admissions for maternity/delivery services
- Skilled nursing facility admissions
- Inpatient rehabilitation facility admissions
- Inpatient mental health and/or chemical dependency services
- Outpatient rehabilitation
- Procedures, surgeries, treatments which may be considered investigational
- Other procedures, including but not limited to:
    - Bariatric surgery
    - Applied behavioral analysis (ABA)
    - Select joint and spinal procedures
    - Select outpatient mental health and/or chemical dependency services
- Certain high-tech imaging
- Sleep studies
- Durable medical equipment, including but not limited to:
    - Power wheelchairs and supplies
    - Select nerve stimulators
    - CPAP and BiPAP
    - Oral appliances
- Certain labs genetic tests
- Gender affirming surgical interventions
- Certain infused prescription drugs administered in a hospital-based infusion center

See the complete list of services that require prior authorization here. We recommend you consult your provider when interpreting the detailed prior authorization list.

If you want more information on how to obtain prior authorization, please call Customer Service at 800-638-0449.

Mental Health and Chemical Dependency Services Benefits are provided for Mental Health Services and Chemical Dependency Services at the same level as and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, and other select outpatient Services must be Prior Authorized.

**Prior authorization requests for out-of-network services**

The Plan does not have a contract with all providers or facilities. Consult your member materials for details regarding your out-of-network benefits. If you are seeking services from an out-of-network provider or facility at contracted rates, a prior authorization is required. You or the out-of-network provider must call us at 800-638-0449 to obtain prior authorization. Please have the following information ready when calling to request a prior authorization:

- Member name and date of birth
- Member ID number and plan number (refer to your member ID card)
- Provider name, address and telephone number
- Hospital or facility name
- Date of admission or date services are to begin
- Service(s) to be performed

**How to request a prior authorization**

We recommend you work with your provider to submit prior authorization requests. Prior authorization requests may be accessed by clicking on the following links:

- General Medical Prior Authorization Fax Form
- Drug Prior Authorization Fax Form
- Behavioral Health Inpatient Fax Form
- Behavioral Health Outpatient Fax Form
- Behavioral Health TMS Fax Form
- Behavioral Health ABA Fax Form
- Carelon Medical Benefits Management (Previously AIM Specialty Health)
- eviCore healthcare

For questions or assistance with the prior authorization request process, please call customer service at 800-878-4445.