The prior authorization process, step by step

Five steps to a determination, then one of three payer answers. Each answer has its own next action. Print this and pin it where the requests get made.

The five steps

STEP 1

Identify the requirement

At the eligibility check, per service code, per plan. Do this before the appointment is confirmed, not after.

STEP 2

Gather the documentation

The order, clinical notes supporting medical necessity, relevant history, and the CPT and ICD-10 codes.

STEP 3

Submit the request

Payer portal, electronic request, or fax. Capture the reference number and the exact submission timestamp.

STEP 4

Track and follow up

Every open request gets an owner and a follow-up date. Silence from the payer is not an answer.

STEP 5

Act on the determination, then watch the expiry

Record, appeal, or send what was asked for. Approvals carry a date range and a unit limit, and both expire.

The payer answers in one of three ways

Approved

You have a number, a date range, and a unit count. All three matter.

- Record the auth number on the client record
- Log the valid-from and valid-to dates
- Book the service inside that window
- Put the number in item 23 of the CMS-1500

Pended

Not a denial. The payer wants something the submission did not carry.

- Read exactly what was requested
- Send only that, same day if you can
- Note the new clock start date
- Tell the patient the date may move

Denied

An adverse determination has an appeal window attached to it.

- Read the stated reason, not the summary
- Request a peer-to-peer review
- File the appeal inside the window
- Do not deliver first and appeal later

An approval is not a guarantee of payment

It says the request met the plan's criteria on the day it was reviewed. Eligibility, benefits, coding, and the authorization's date range are checked again when the claim adjudicates.

Since January 1, 2026, payers covered by the CMS Interoperability and Prior Authorization final rule (CMS-0057-F) must answer expedited requests within 72 hours and standard requests within seven calendar days, and must state a specific reason for a denial. Appeal windows shown are the federal minimums for group health plans under 29 CFR 2560.503-1. Item 23 of the CMS-1500 is the prior authorization number field, per the NUCC instruction manual. Your state and your plan contract may be stricter, so read the provider manual.

The prior authorization request checklist

Work down this list before you submit. A request that goes out complete is the one that comes back in days rather than weeks.

The clocks to plan around

REQUEST TYPE	REGULATED CEILING	WHAT TO PLAN FOR
Standard request	Seven calendar days for payers covered by the CMS rule, from January 1, 2026	Book auth-required services at least a week out
Expedited request	72 hours under the same rule	State the clinical urgency in writing, in the request itself
Appeal of a denial	At least 180 days to file, for plans under the federal claims rules	File in days, not months, while the notes are fresh
Appeal decision	30 days pre-service, or 72 hours where care is urgent	Add the appeal window to the treatment plan date

1. BEFORE YOU REQUEST

- [ ] Coverage confirmed active for the date of service
- [ ] Auth requirement checked **per service code**, not per patient
- [ ] Plan's own criteria for this service read, not assumed
- [ ] Step therapy requirements identified and documented
- [ ] In-network status of every rendering provider confirmed
- [ ] Place of service confirmed against the plan's rules

2. IN THE REQUEST PACKET

- [ ] Patient name, date of birth, and member ID exactly as the plan holds them
- [ ] Ordering and rendering provider names and NPIs
- [ ] CPT or HCPCS code for every service requested
- [ ] ICD-10 diagnosis codes supporting medical necessity
- [ ] Requested units, visits, or dosage, plus the date range
- [ ] Clinical notes that state the diagnosis and the rationale
- [ ] Evidence of anything tried and failed first
- [ ] Letter of medical necessity, where the plan asks for one

3. ON SUBMISSION

- [ ] Reference or case number captured
- [ ] Date, time, and channel of submission logged
- [ ] Named owner assigned to the request
- [ ] Follow-up date set before the regulated ceiling expires
- [ ] Urgency flagged in writing, with the clinical reason, if expedited

4. ON APPROVAL

- [ ] Authorization number recorded on the client record
- [ ] Valid-from and valid-to dates recorded
- [ ] Approved units or visits recorded, and counted down as used
- [ ] Approved codes checked against what you plan to bill
- [ ] Appointment confirmed inside the validity window
- [ ] Number added to item 23 of the claim before submission

5. ON DENIAL

- [ ] Stated denial reason read in full
- [ ] Reason classified: documentation, criteria, coding, or eligibility
- [ ] Peer-to-peer review requested where the call is clinical
- [ ] Appeal deadline diarized the day the denial arrives
- [ ] Appeal packet built around the reason given
- [ ] Patient told what is covered before care goes ahead

6. BEFORE THE APPOINTMENT

- [ ] Authorization still inside its date range
- [ ] Units still available for this visit
- [ ] Reschedules rechecked against the validity window
- [ ] Treatment plan matches the approved codes
- [ ] Patient's financial responsibility confirmed and communicated

The open request log

One line per request, from submission to determination. An open request with no owner and no follow-up date is the one that turns into a write-off.

PATIENT	PAYER / PLAN	CODE(S)	SUBMITTED	REFERENCE #	OWNER	FOLLOW-UP	DETERMINATION	AUTH # / VALID TO

Two dates decide whether the work gets paid

The follow-up date keeps the request moving before the payer's clock runs out. The valid-to date keeps the appointment inside the window the payer actually approved.

Keep this log where the whole front desk can see it, not in one person's inbox. Where your practice management system records authorizations on the client record, use that instead and keep this sheet for the requests that are still open. Prior authorization requirements are specific to the plan and the service code, so check both every time.