Authorizations

Provider Portal quick start guide

We require authorization for certain drugs, services and procedures. In these cases, providers will submit clinical documentation and medical records demonstrating that the drug, service or procedure is medically necessary.

Use our Provider Portal to check authorization requirements and to submit authorization requests. The portal will prompt and redirect you, when appropriate, outside of the portal to submit certain requests (i.e., for drugs, or for services and procedures managed by EviCore or TurningPoint).

Note: authorizations are sometimes called *referrals* in the Provider Portal.

In this guide

Determine authorization requirements

Before you submit an authorization request for one of our members, our Provider Portal will first confirm:

- ✓ **Authorization requirements**: whether authorization is required for that specific service / procedure for that member
- ✓ **Coverage**: if the service / procedure is covered for that member
- ✓ **Submission platform**: where you will submit the authorization request (directly in our portal, via EviCore or TurningPoint or another method)

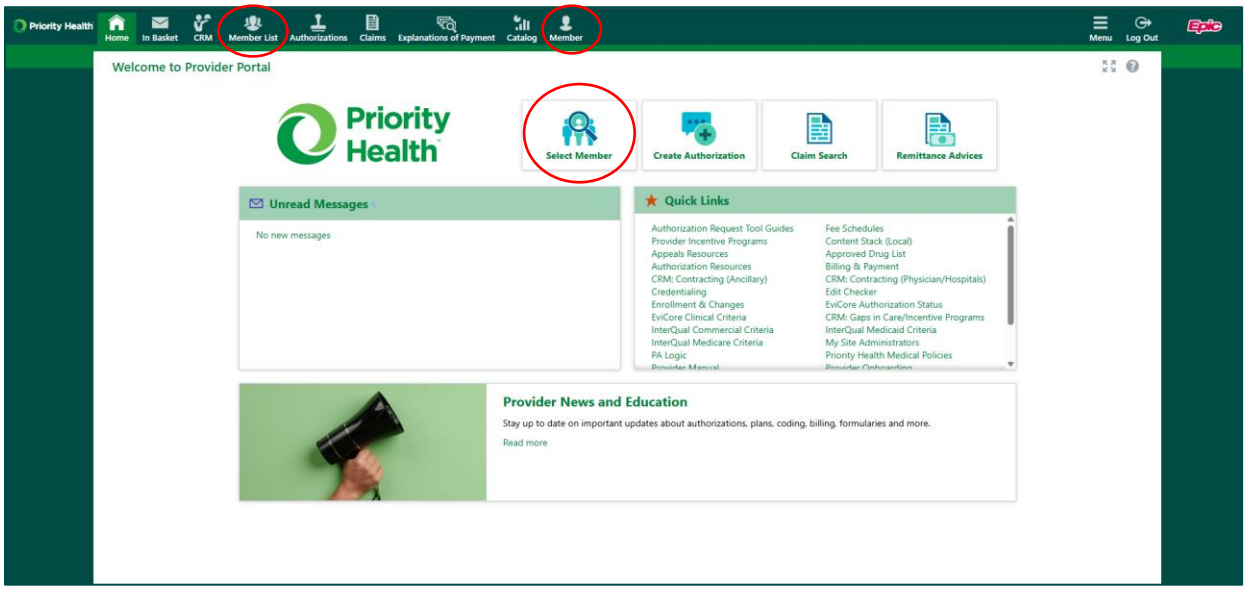
Follow the steps below to complete this check.

Step 1: Access our Provider Portal

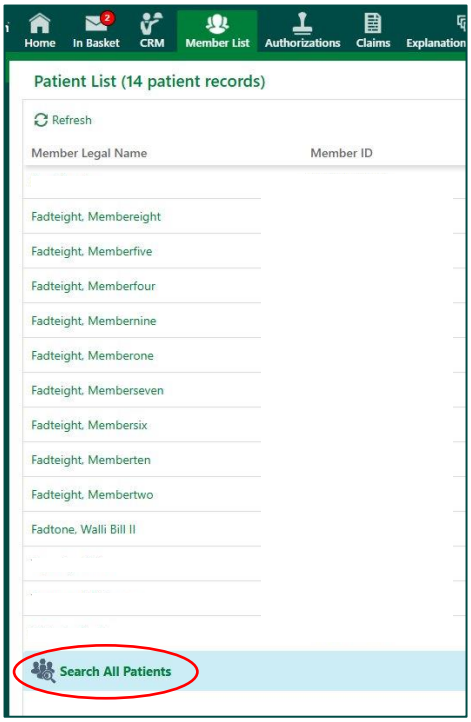
Log into your Provider Portal account at ***provider.priorityhealth.com***.

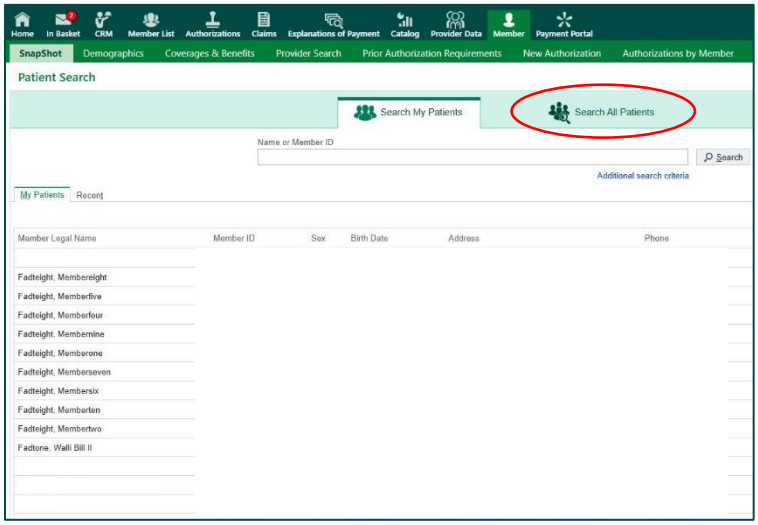
Step 2: Look up the member

From the portal home screen, use **Select Member**, **Member List** or **Member** to search for the member that you need to request an authorization for.



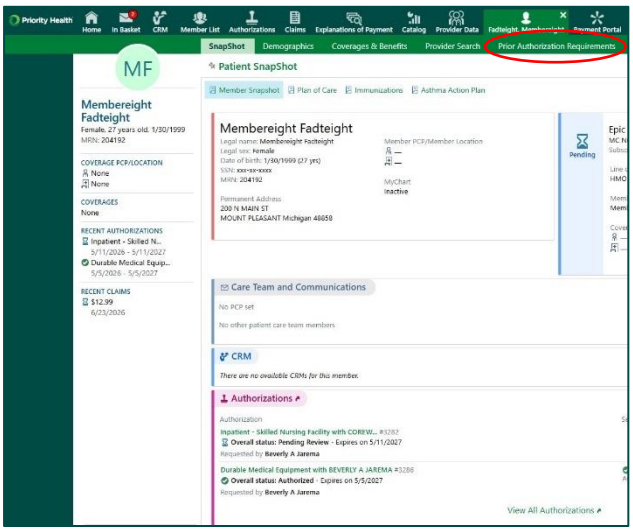
Choose **Search All Patients** if the member you're looking for isn't there. (You'll need their Member ID or four other pieces of identifying information.)

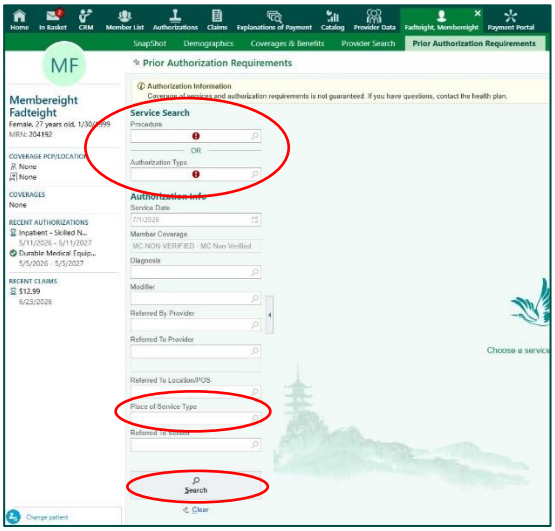




Step 3: Select Prior Authorization Requirements

Once you locate the member, click their name to open Member Inquiry / their Patient Snapshot. Click the **Prior Authorization Requirements** tab to initiate your search (see the guides linked under Submit an authorization request for support with this search criteria).



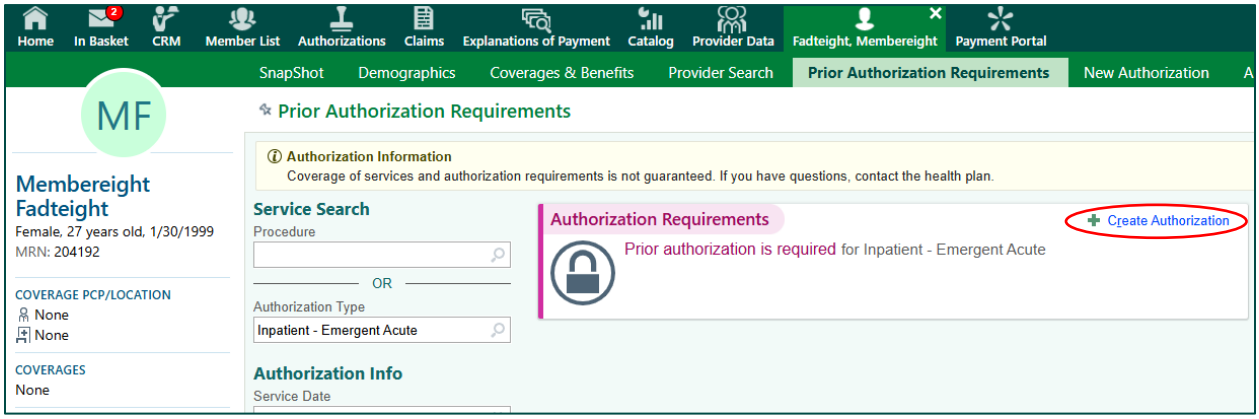


When selecting an **Authorization Type**, be sure to select the one that **most closely matches** the procedure or service.

When you click **Search**, the Authorization Requirements box will appear to the right side of the search criteria with information and instructions:

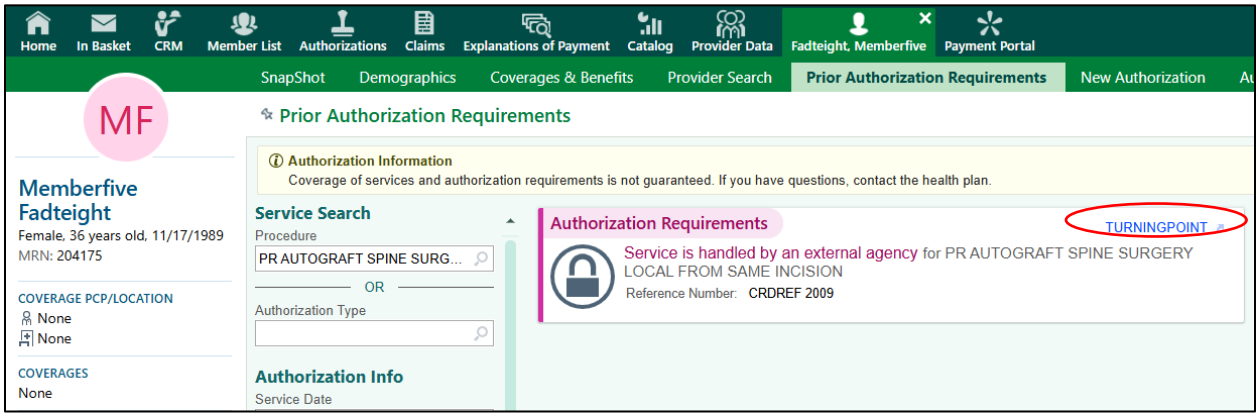
Outcome 1: Prior authorization is required

This outcome indicates prior authorization is required for the service or procedure, and you would submit the authorization in the portal. Click **Create Authorization** to begin your request. (See the guides linked under Submit an authorization request for additional instructions.)



Outcome 2: Prior authorization is required through a third party

When a third party vendor manages a service or procedure on our behalf, the Authorization Requirements box will read: Service is handled by an external agency. This includes authorizations that must be requested through TurningPoint and EviCore. Click the hyperlinked vendor name to SSO to their site to complete your authorization request.

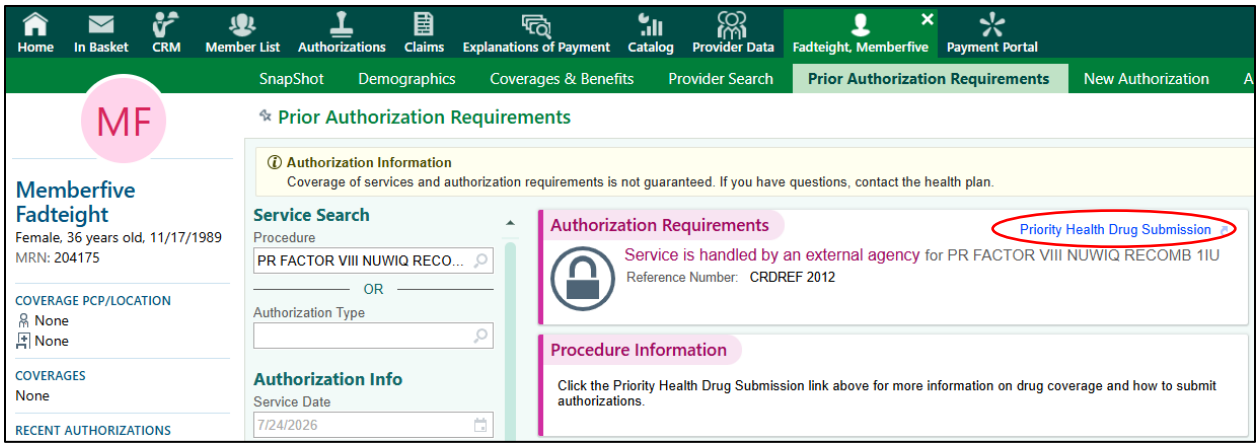


Outcome 3: Pharmacy authorization

For pharmacy authorizations, the Authorization Requirements box will read: Service is handled by an external agency.

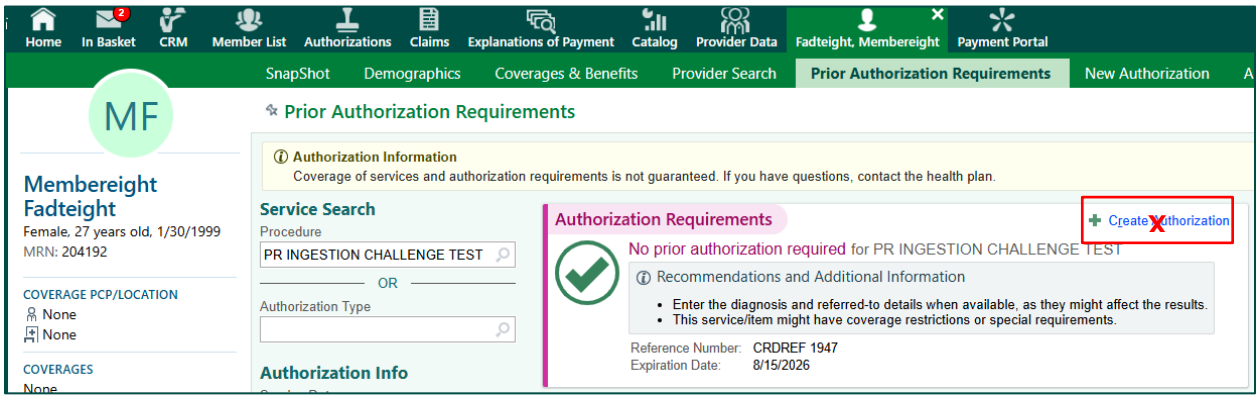
***Important**: Pharmacy authorizations are handled by Priority Health, not an external agency. "External" means the request is handled outside the portal.*

Click the hyperlinked text that reads "Priority Health Drug Submission." This will take you to our Provider Manual's Drug Information page. Follow the directions there.



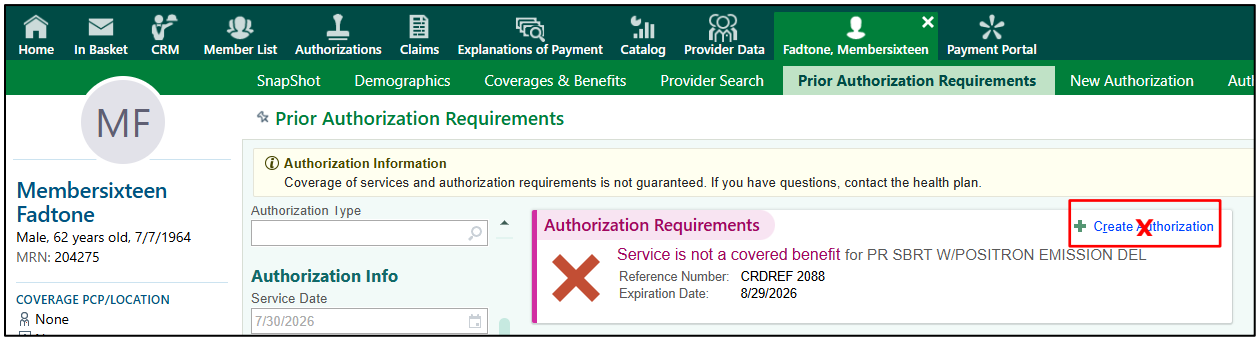
Outcome 4: No authorization is required

When no authorization is required for a particular service or procedure, the Authorization Requirements box will read: No prior authorization required. Do **NOT** click Create Authorization. Simply submit your claim for the service or procedure after it's complete.



Outcome 5: Not a covered benefit

When the procedure or service isn't covered, the Authorization Requirements box will read: Service is not a covered benefit. Do **NOT** click Create Authorization. Our system runs an individualized benefit check for the member, ensuring you aren't spending time requesting authorizations for procedures that won't be covered.



Submit an authorization request

Use the information below to determine the correct authorization type for your request. **Click the underlined authorization type below** to open specific instructions for submitting your request.

Inpatient requests

Use the guides below when the member is receiving services in a facility under an inpatient or post-acute level of care setting.

- **Acute & OB/GYN**: urgent / emergent admissions, conversions from outpatient / observation to inpatient
- **Behavioral Health**: MH inpatient or residential, psychiatric intensive care, ECT (inpatient), SUD detox, SUD residential / rehab
- **Elective**: non-emergent, planned admissions
- **NICU / Transplant**
- **Post-Acute**: long-term acute care, inpatient rehabilitation, subacute rehabilitation

Outpatient requests

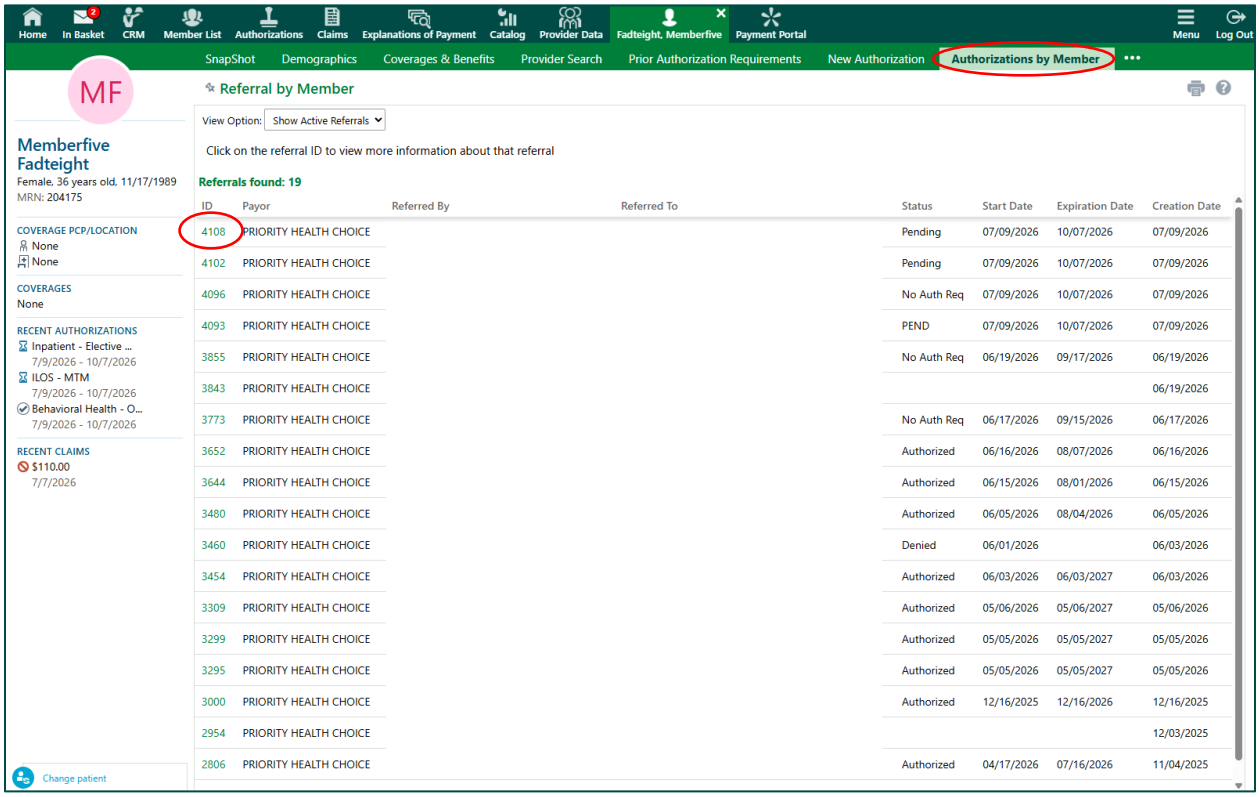
Use the guides below for all other requests, including services provided in a facility but as an outpatient or ambulatory level of care setting.

- **Behavioral Health**: mental health partial hospitalization program, substance use disorder partial hospitalization program, trans magnetic stimulation (TMS), applied behavioral analysis (ABA)
- **DME**: all equipment necessary for treatment, mobility, accessibility and safety within the home (i.e., wheelchairs, hospital beds, CPAPs, wound pumps and supplies)
- **Home Health**: health care services provided wherever the member calls “home” (i.e., home infusion, wound care, palliative care, home physician visits, nursing, therapy and services provided by home health agencies)
- **Outpatient**: services provided to a member outside of an inpatient setting (i.e., doctor’s office visits, off-campus hospital, ambulatory surgery center and outpatient therapy)
- **In Lieu of Services (ILOS)**: food delivery services covered for some Medicaid members

Review / status submitted authorizations

From Member Inquiry / a member's Patient Snapshot, click **Authorizations by Member** to find submitted authorization requests, including **Status**.

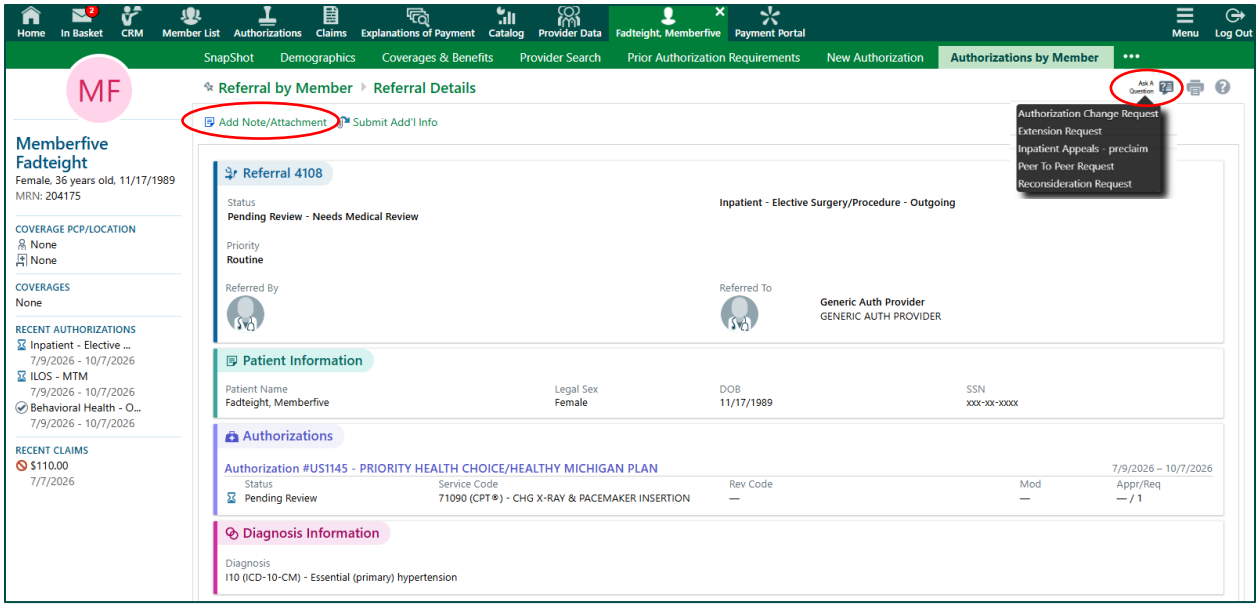
Click the **Authorization ID** (green number in the first column) to view additional authorization details.



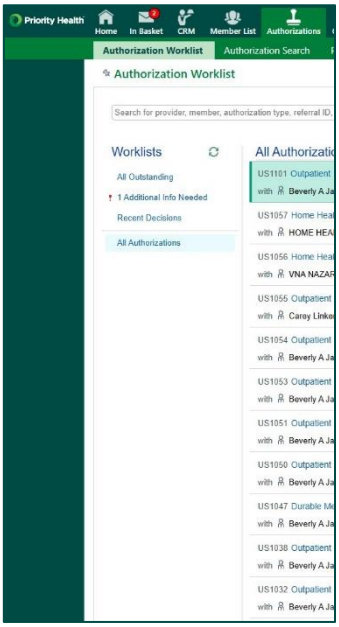
Add a note or attachment to the selected request by clicking **Add Note/Attachment** in the upper left corner.

Click **Ask A Question** in the upper right corner to submit:

- Authorization change requests
- Extension requests
- Peer to Peer requests
- Reconsideration requests



Alternatively, click **Authorizations** in the top menu to open your **Authorizations Worklist**.



Here you can **check the status** of your requests:

- **All Outstanding**: see pending authorization requests and their status
- **Recent Decisions**: see recently decided authorization requests and their status
- **All Authorizations**: see a complete list of all requests
- **Additional Info Needed**: requests our team needs more information on to make a determination (learn how to submit additional information)

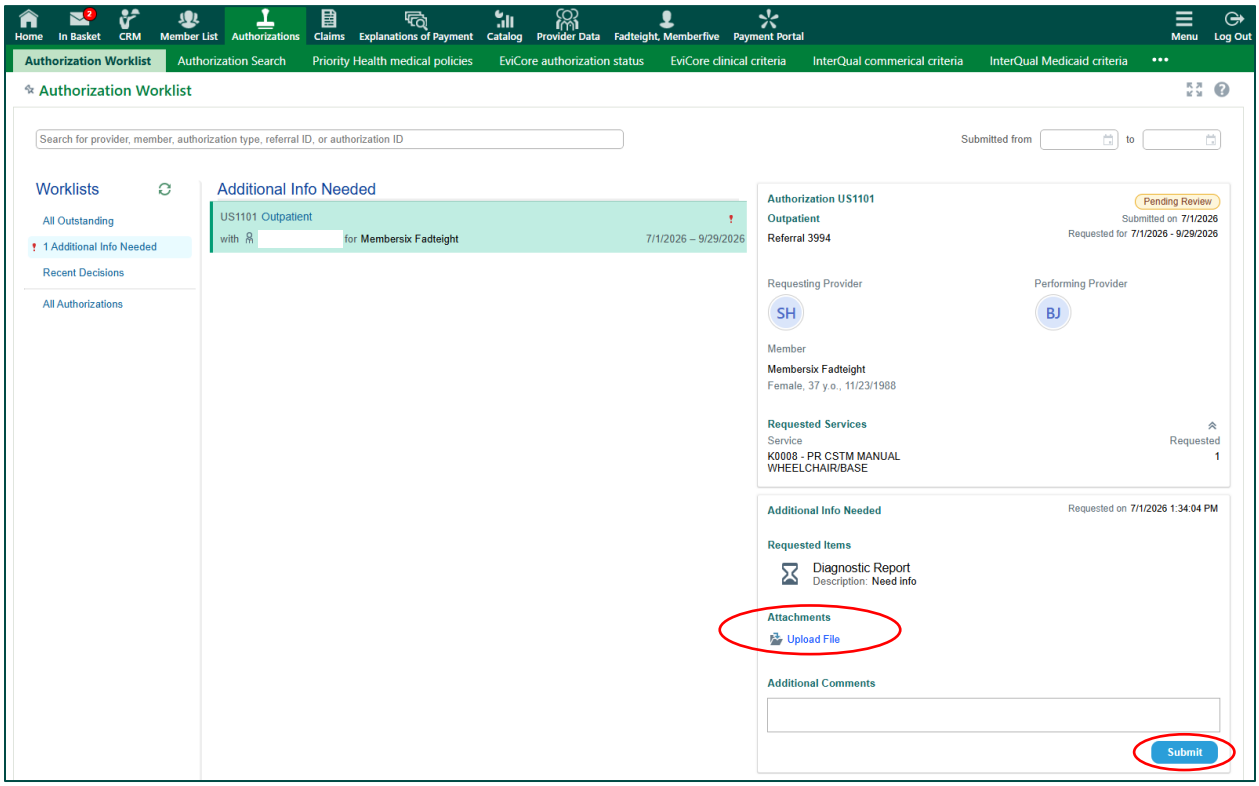
You will be notified of authorization decisions in your In Basket, in the **Referral Notifications Letter Activity** folder.

Submit additional information, by request

Outpatient authorizations

Select **Additional Info Needed** under your Worklists to filter authorization requests that require more information to make a determination.

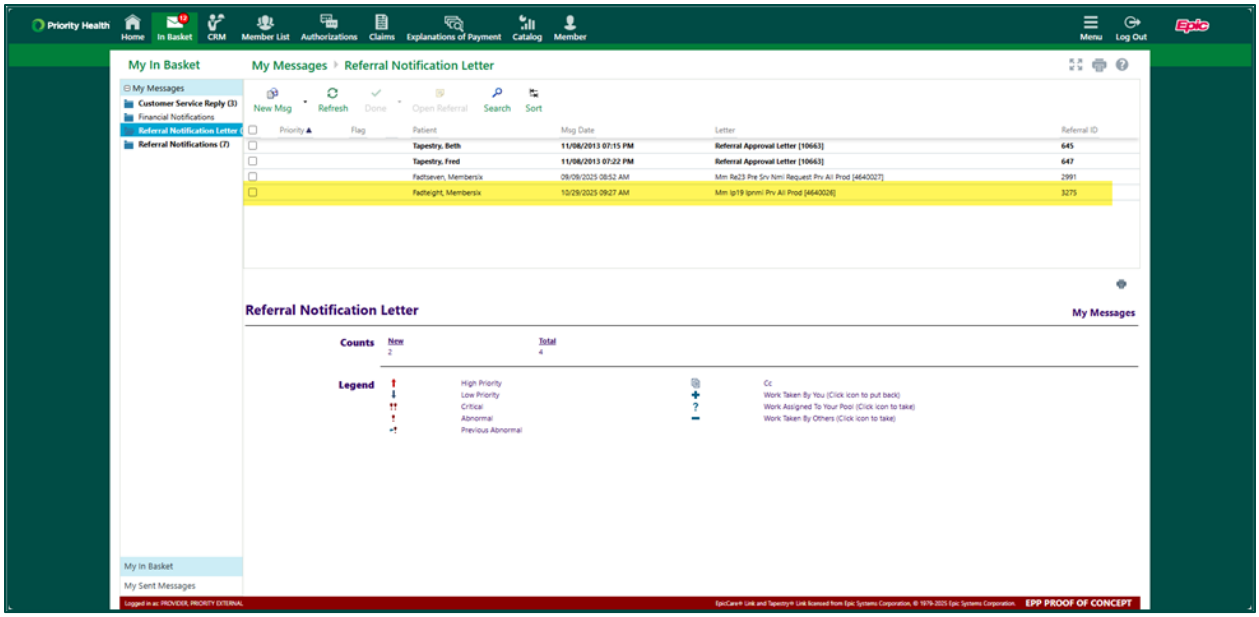
Select an authorization request and check what's listed under **Requested Items**. Select **Upload File** and add a file (up to 100MB) that responds to the request. Add additional comments if necessary, then click **Submit**.



Inpatient authorizations

Requests for additional information for inpatient authorizations are sent through the Provider Portal's **In Basket** function. Unless you elect otherwise in the portal, you'll receive an email notification when a request for additional information is sent to you.

1. Open your **In Basket**.
2. Navigate to the **Referral Notifications Letter Activity** folder.
3. Select a message to review the request for additional information.
4. Click **Reply**.
5. Type a note and/or upload a document. Click **Send Message**.


Priority Health
Home
In Basket
CRM
Member List
Authorizations
Claims
Explanations of Payment
Catalog
Member
Menu
Log Out
My In Basket
My Messages
Referral Notification Letter
My Messages
Customer Service Reply (3)
Financial Notifications
Referral Notification Letter
Referral Notifications (7)
New Msg
Refresh
Done
Open Referral
Search
Sort
Priority
Flag
Patient
Msg Date
Letter
Referral ID
Tapestry, Beth
11/08/2013 07:15 PM
Referral Approval Letter [10663]
645
Tapestry, Fred
11/08/2013 07:22 PM
Referral Approval Letter [10663]
647
Factseven, Membersix
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2991
Facteight, Membersix
10/29/2025 09:27 AM
Mm Ip19 Ipnmi Prv Al Prod [4640026]
3275
Referral Notification Letter
My Messages
Counts
New
2
Total
4
Legend
High Priority
Low Priority
Critical
Abnormal
Previous Abnormal
Cc
Work Taken By You (Click icon to put back)
Work Assigned To Your Pool (Click icon to take)
Work Taken By Others (Click icon to take)
My In Basket
My Sent Messages
EPP PROOF OF CONCEPT

Request a Peer-to-Peer

In many cases, if your authorization request is denied, you can request Peer to Peer (a.k.a. Peer Review) with one of our Medical Directors.

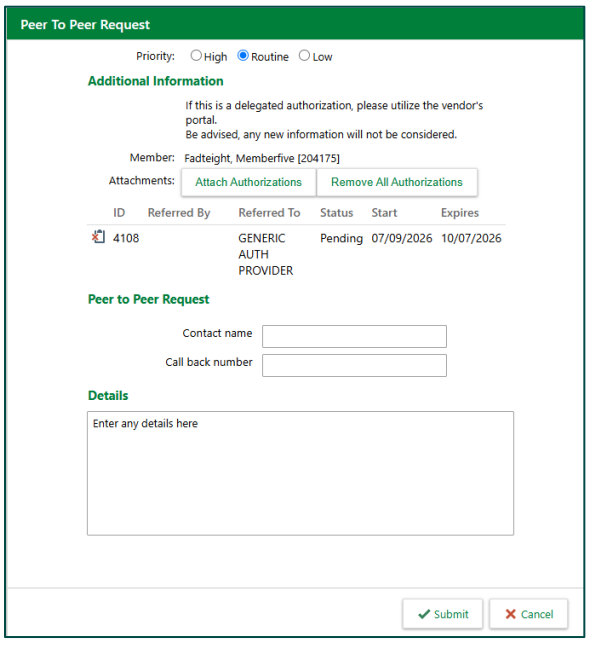
Before submitting your request

See our Peer-to-Peer policy for details on when this option is available to you.

Submit a Peer-to-Peer request

1. Find the authorization you'd like to request a Peer-to-Peer for and click the Authorization ID to open the details screen.
2. Click **Ask A Question** in the top right corner, then select **Peer-to-Peer Request** from the resulting options.
3. Enter your name in the **Contact name** field
4. Enter your phone number in the **Call back number** field
5. In the **Details** field, enter:
    a. The name of the MD that'll participate in the peer review on behalf of your facility or group
    b. The MD's direct phone number
    c. The MD's availability – include several times
6. Click **Submit**.

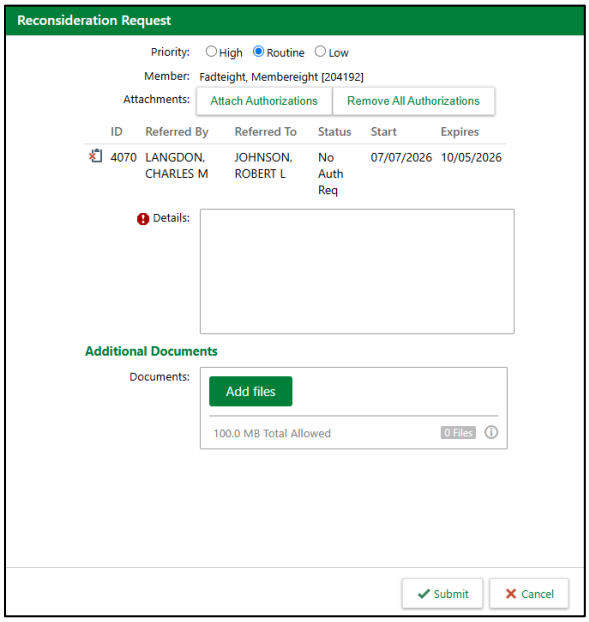
Someone from our team will contact you to schedule the Peer-to-Peer.



Request a reconsideration

If your authorization request is denied and you're able to provide additional documentation to support medical necessity within 24 hours of the denial, you may submit a Reconsideration Request instead of going through the appeal process.

1. Find the authorization you'd like to request a Peer-to-Peer for and click the Authorization ID to open the details screen.
2. Click **Ask A Question** in the top right corner, then select **Reconsideration Request** from the resulting options.
3. Enter any supporting information in the **Details** area.
4. Attach applicable documentation to support medical necessity using the **Add files** button.
5. Click **Submit**.



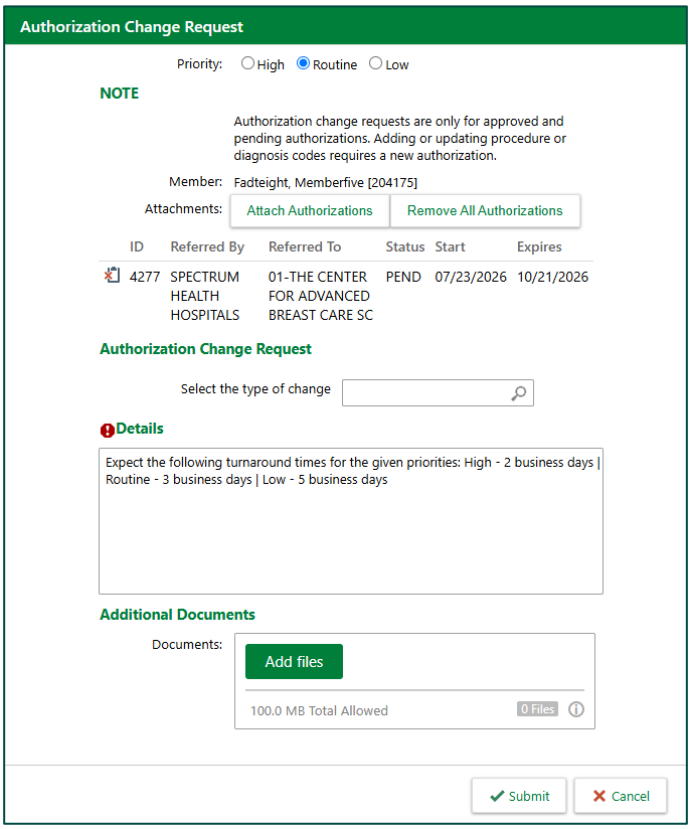
Change or cancel an authorization request

For pending or approved requests, follow the instructions outlined below.

1. Find the authorization you'd like to request an extension for and click the Authorization ID to open the details screen.
2. Click **Ask A Question** in the top right corner, then select **Authorization Change Request** from the resulting options.
3. Leave the **Priority** set to Routine (default).
4. Under Authorization Change Request, **select the type of change**. Click the magnifying glass icon to open a list of options:
    a. Change in date of service or DME rentals
    b. Change in units, visits or days (not to be used for inpatient extensions)
    c. Change provider or facility
    d. Request to void a pending or an approved authorization
    e. Request to expedite a pending authorization
5. Under **Details**, enter any information to support your request.
6. Under Additional Documents, use the **Add files** button to upload any relevant attachments, if applicable.
7. Click **Submit**.

Limits to changing an existing medical authorization:

- Adding or updating procedure or diagnosis codes requires a new authorization
- No changes can be made to a denied or voided authorization

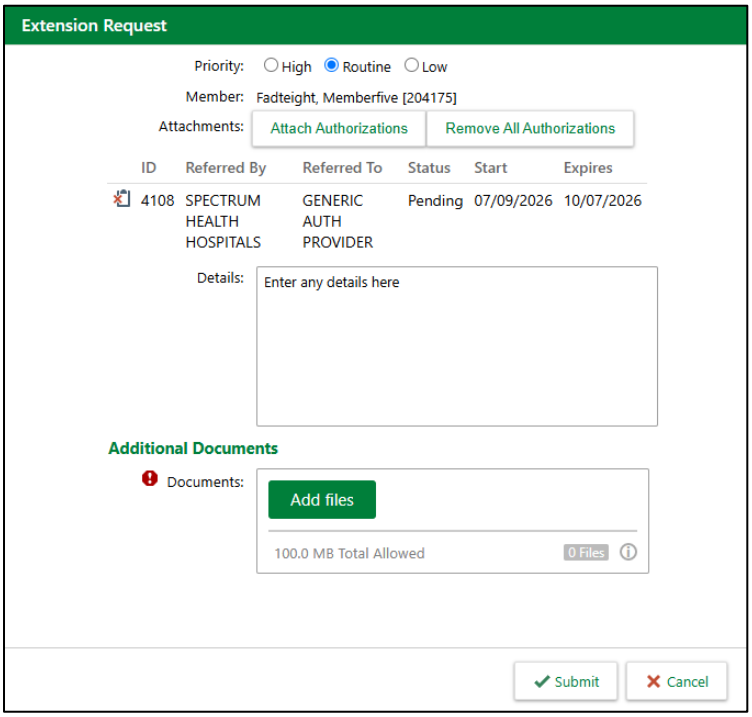


Request an extension

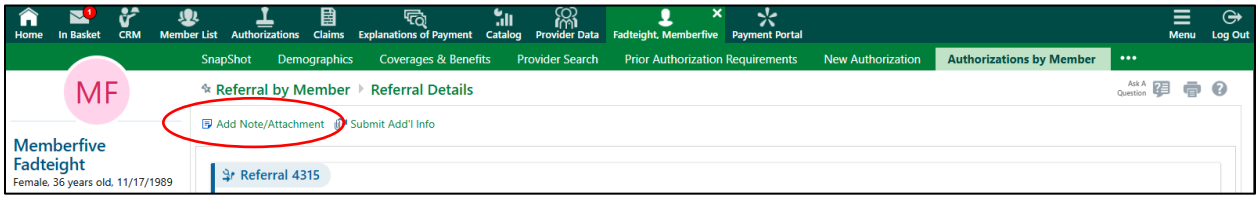
For all requests, follow the instructions outlined below.

1. Find the authorization you'd like to request an extension for and click the Authorization ID to open the details screen.
2. Click **Ask A Question** in the top right corner, then select **Extension Request** from the resulting options.
3. Leave the **Priority** set to Routine (default).
4. In the **Details** field, enter:
    a. For outpatient, note the starting date of the requested extension.
    b. For inpatient and outpatient, note the ending date of the requested extension.
    c. Note the total number of days or units requested
    d. Enter any additional information to support your request
5. Upload additional documents using the **Add files** button. Be sure to upload clinical documentation here. Priority Health can't make a determination on your request without it. Failure to upload will cause processing delays.
6. Click **Submit**.

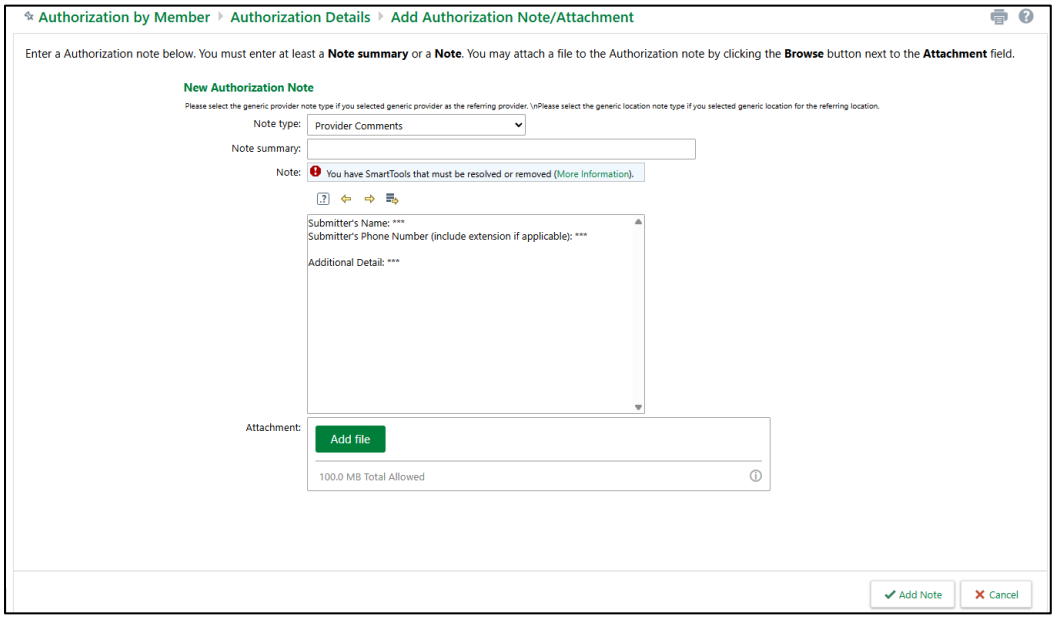
***Behavioral Health**: If you're requesting inpatient ECT at the same time as an inpatient stay extension, you must upload both the clinical documentation supporting the ECT authorization and the information that supports the inpatient days extension request.*



Enter inpatient discharge information



1. Find the authorization you'd like to request an extension for and click the Authorization ID to open the details screen.
2. Click **Add Note/Attachment** above the Referral Number.

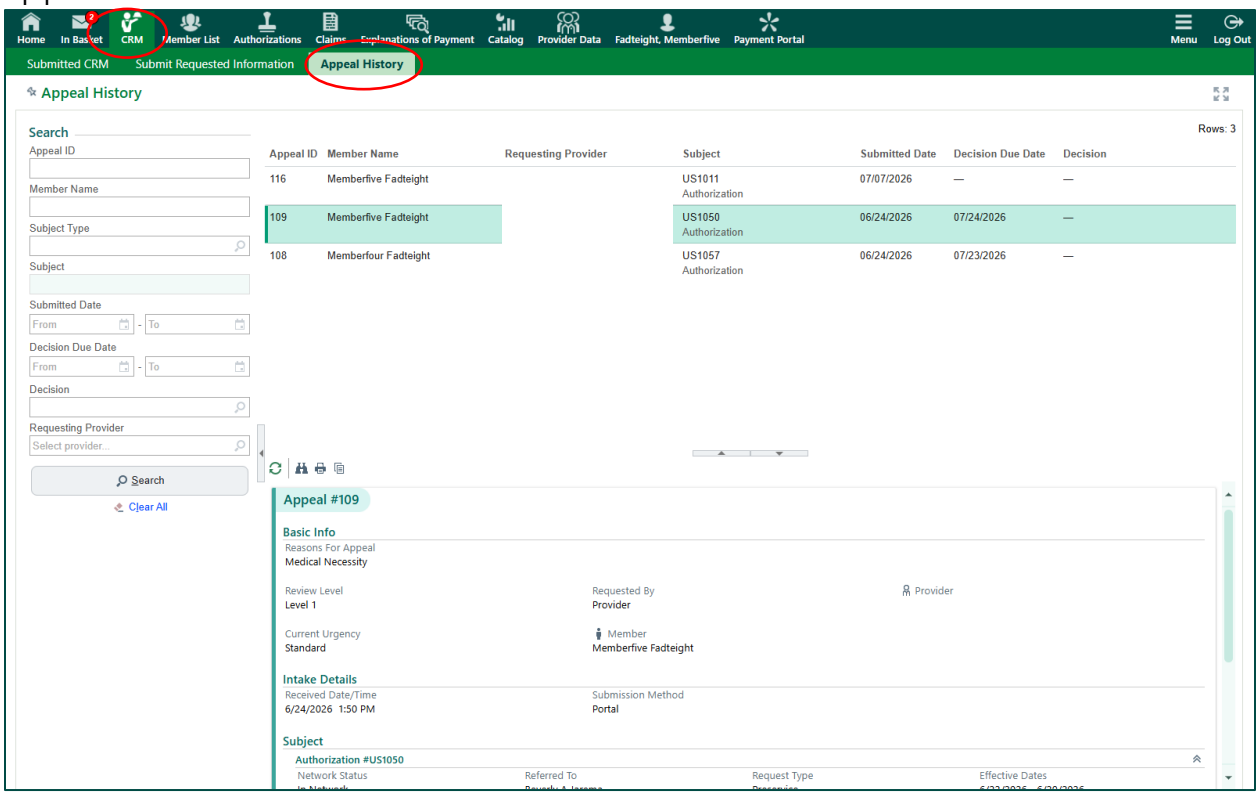


3. On the resulting screen, leave the **Note Type** set to Provider Comments. In the **Note Summary** field, enter Discharge.
4. In the **SmartTools text box**, remove the asterisks and enter your name, your direct phone number (include any extensions) and under Additional Detail, enter the discharge date and disposition.
5. Click **Add Note**.

Check your authorization appeals

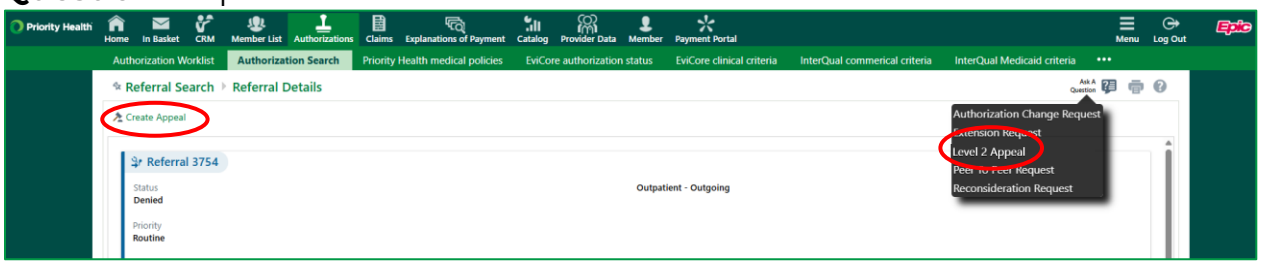
Check an existing appeal

Under CRM in the main menu, click Appeal History to search, view and status appeals.



Submit a new appeal

Navigate to the Referral Details page of a denied authorization you'd like to appeal and select **Create Appeal**. If the authorization request has already been appealed and denied, you can select **Level 2 Appeal** from the **Ask A Question** dropdown menu.



Refer to our Provider Manual's Appeals section for appeals timelines and submission processes:

- Medicare authorization appeals
- Commercial & Medicaid authorization appeals

File upload requirements

File types	Accepted file types include: jpeg, png, jpg, bmp, gif, pdf, docx, doc, txt, xlsx, xls or pdf
Document size limit	25MB per file
Image size limit	5MB per image file
Total uploads limit	Cannot exceed 100MB