



Frequently asked questions about prior authorization

Prior authorization is a process through which health plans verify that the care people receive is safe, effective and covered by their health plan before they undergo a procedure or surgery. Think of it as an important checkpoint that helps minimize the chances of an employee receiving an unexpected medical bill – though it is not required for most types of care.

What is Prior Authorization?

Prior Authorization programs are a medical necessity process built to help improve health care quality and cost outcomes for certain procedures. The process is designed to help reduce variation in care, prevent avoidable and duplicative procedures and improve the employee experience.

98%

of claims do not require prior authorization¹

How does the prior authorization process work?

If prior authorization is required, a clinical coverage review will be conducted before the service is performed to determine whether it's medically necessary based on evidence-based clinical guidelines. Prior authorization must be completed before the service is performed.

What procedures are included in the Prior Authorization programs?

Services include, but are not limited to:*

- Injectable medications
- MSK surgeries
- Sleep testing
- Radiology procedures

What percentage of claims require prior authorization?

Today, less than 2% of UnitedHealthcare claims require a prior authorization review.¹ Of those claims, over 93% end up getting approved.²

To further reduce prior authorizations where appropriate, UnitedHealthcare also introduced the Gold Card Program. This program recognizes provider groups that consistently follow evidence-based care guidelines by reducing their total prior authorization requirements – resulting in an average 30% reduction in prior authorizations per year for qualified Gold Card provider groups.³

How can you determine if prior authorization is required for a procedure?

To confirm prior authorization requirements, call the toll-free member number on your health plan ID card, or go to Claims & Accounts > Prior Authorization on the UnitedHealthcare® app or myuhc.com®.

How can you confirm if you are responsible for obtaining a prior authorization?

Your benefit coverage documents will summarize the prior authorization requirements. Generally, your network provider – a physician, facility or other health care professional who contracts to participate in the UnitedHealthcare network – will facilitate this process for you. When seeking services from an out-of-network provider, you will be responsible for obtaining prior authorization.

If you are in a UnitedHealthcare Options PPO plan, you will be responsible for obtaining prior authorization, regardless of whether the service is provided by a network or an out-of-network provider. Although your provider may not be required to call, they may call, as a courtesy to you, to obtain prior authorization on your behalf.

How will you be notified of the outcome of your prior authorization request?

You will receive a determination letter by mail and a copy will be sent to your provider. You may also check the status of your request under Claims & Accounts on the UnitedHealthcare app or myuhc.com.

How long is a prior authorization number valid?

A prior authorization number is valid for 45 calendar days. An authorization is specific to the procedure requested and can only be used once within the 45-day period.

Are you responsible for the cost of the service if it's determined that it's not medically necessary?

If it is determined that the service is not medically necessary, the claim for the service will be denied. You can be billed by a network provider for claims that are denied for services that did not meet medical necessity, if the provider obtained adequate written consent from you before performing the service. If you have questions about the determination, you may want to talk to your provider.

How do you appeal a request that did not meet medical necessity?

If the request does not meet medical necessity, the determination letter will include an explanation for the decision, the criteria used and available appeal rights.

Here's a closer look at how it works



Identify

Patient visits a physician who then recommends a test, procedure or service that requires prior authorization



Inquire

For network services, the physician contacts UnitedHealthcare, but for out-of-network services the patient must contact UnitedHealthcare



Verify

UnitedHealthcare reviews the request to verify the service is covered and medically necessary – and a determination is made



Inform

Physician and patient review the decision and plan a course of action



Claim

Claim is submitted for service rendered

Questions?

Call the toll-free number on your health plan ID card

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*Individuals should check their specific coverage documents for details.

¹ Based on UnitedHealthcare Employer & Individual self-funded book of business, calendar year 2024.

² Based on UnitedHealthcare Employer & Individual self-funded book of business, calendar year 2024. 7% of prior authorizations required further review to validate comprised of: 3.6% denied due to missing clinical information; 3.0% denied due to plan design/eligibility; 0.4% integrity and fraud review and 0.3% medical necessity/prior authorization.

³ Based on UnitedHealthcare Employer & Individual self-funded book of business, April 1, 2022–March 30, 2024.

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