MEDICAL NECESSITY AND PRIOR AUTHORIZATION TIMEFRAMES AND MEMBER RESPONSIBILITIES

Medical Necessity or Medically Necessary: Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care.

Prior Authorization: We must approve some services before you receive them. This is called Prior Authorization or preservice review. If you need a service that we must first approve, your In-Network provider must call us for Prior Authorization. An example of a service needing Prior Authorization is any kind of inpatient hospital care (except maternity care).

If you choose to see an Out-of-Network provider (or you have a plan with access to the PHCS network), YOU must call us for Prior Authorization.

The number to call for Prior Authorization is (800) 865-5922 and can also be found on the back of your ID card. Failure to receive Prior Authorization as appropriate may result in the denial of claims. Charges for health care services that are not Covered Services because the services are not Medically Necessary or Prior Authorization was not obtained are not eligible for payment.

What is the timeframe for receiving Prior Authorization?

- For emergency inpatient admissions, notification of admission must be provided to us within 2 business days after services have started or within 1 business day after conversion from observation to inpatient status.
- For non-urgent medical services, a decision on the Prior Authorization request will be made within 7 days of us receiving the request.
- For urgent medical services, a decision on the Prior Authorization request will be made within 72 hours of us receiving the request.