Understanding Preauthorization

PacificSource requires written preauthorization for coverage of certain medical services, surgical procedures, and prescription drugs. The term “preauthorization” simply refers to a process by which an insurer determines in advance whether or not a specific service or drug will be reimbursed.

How It Works

Your medical provider can request preauthorization from our Health Services Department through InTouch, our secure online portal for members. If your provider will not request preauthorization for you, you may contact us yourself and we will assist in facilitating the process. We use established, science-based criteria to make coverage decisions. In some cases, we may ask for more information or require a second opinion before authorizing coverage.

A preauthorization does not imply that the entire cost of the service will be covered. Your plan’s deductible, co-insurance, and co-pays will still apply.

Preauthorization determination is for payment purposes only and in no way seeks to influence clinical decisions or dictate treatment options. The ultimate decision to proceed with treatment is to be made by you and your healthcare provider.

Why Preauthorization Is Necessary

Preauthorization is necessary to determine if certain services and supplies are covered under your plan, and if you meet the plan’s eligibility requirements.

How You’ll Be Notified

We’ll let you know if your preauthorization request is approved or denied by letter, fax, or electronic transmission to the hospital, the provider, and you. If time is a factor, notification will be made by phone and followed up in writing.

What to Do if Your Treatment Is Not Preauthorized

If your treatment is not preauthorized, you can still seek treatment, but you will be held responsible for the expense if it is not medically necessary or is not covered by your plan.

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Any time you are unsure if an expense will be covered or have any questions about your benefits, we encourage you to contact our Customer Service Department.

Additional Information

**Third Party Participation**
We reserve the right to employ a third party to perform preauthorization procedures on our behalf.

**Medical Emergencies**
In a medical emergency, services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient are covered without preauthorization requirements. We must be notified of an emergency admission to a hospital or specialized treatment center as an inpatient within two business days.

** Appealing Denied Preauthorization Requests**
If your provider’s preauthorization request is denied as not medically necessary or as experimental, your provider may call our Health Services Department at (888) 691-8209 to schedule a peer-to-peer consultation. You retain the right to appeal our benefit determination independently from your provider.

View Our Preauthorization Lists
As we continually review new technologies and standards of medical practice, these lists are subject to revision. You can find the most current preauthorization list on our website at PacificSource.com/member/preauthorization.aspx.

Also keep in mind that your plan may not cover all the items listed. Check your benefit materials or contact our Customer Service Department if you have any questions about your plan benefits.

If you have questions you are welcome to contact our Customer Service Department at (888) 977-9299 or email cs@pacificsource.com.