Guidelines for Urgent Prior Authorizations Requests

We continue to receive prior authorization requests marked "urgent" for services scheduled more than a week in advance. Per the Centers for Medicare & Medicaid Services, urgent should only be used when:

- Applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Submission guidelines can be found in the table below.

For	Submission options
An urgent service that meets the CMS urgent definition	• Online – Log in at **hap.org**; select *Authorizations.* – In the event classification, choose **pre-service urgent.** • Call **(313) 664-8950** (Monday through Friday from 8 a.m. to 4:30 p.m.) Urgent authorization requests are determined within 72 hours.
A service scheduled in 72 hours that does **not** meet the CMS urgent definition	• Online – Log in at **hap.org**; select *Authorizations*. – In the event classification, choose **pre-service.** – Follow up by calling **(313) 664-8950** and requesting authorization be processed as soon as possible. (Monday through Friday from 8 a.m. to 4:30 p.m.) Pre-service requests are determined within 14 days.
Retro or post-service requests	Online. Log in at **hap.org**; select *Authorizations*. In the event classification, choose **post-service.** These requests should never be marked urgent. Post-service requests are determined within 14 days for Medicare members and within 15 days for commercial members.
Important! Faxed clinical information should only be marked "urgent" if it's submitted for an urgent service by CMS definition.	

Following the guidelines above will ensure more efficient processing of prior authorization requests.