UNDERSTANDING THE INSURANCE AUTHORIZATION PROCESS

WHY AUTHORIZATION IS NEEDED

Before your surgery can be scheduled, your insurance company may require a process called "prior authorization" (also known as "precertification", “pre-determination”, or "pre-approval"). This is not a guarantee of payment, but it is a necessary step to confirm that your insurance plan is likely to cover the procedure.

HOW LONG CAN IT TAKE?

Insurance authorization can take up to **4-6 weeks** or more for approval. Delays may occur if your insurance company requests additional medical records, specialist notes, or testing information.

WHAT HAPPENS DURING THE AUTHORIZATION PROCESS

YOUR PROVIDER SUBMITS DOCUMENTATION

Your surgeon's office will send detailed medical records, test results, and surgical plans to your insurance company.

INSURANCE COMPANY REVIEWS THE REQUEST

A medical reviewer (may or may not be a doctor) checks your records to confirm the surgery meets their guidelines for coverage.

THE DECISION IS MADE

The insurance company will approve, deny, or request additional information. If your the request was denied, your surgeon’s office will help with the appeal process, which may add more time.

WHAT CAN YOU DO?

- Stay in contact with your surgeon‘s office for updates
- Respond quickly to any requests for information

For any questions related to the authorization process, please call **(248) 357 - 5100** and ask to speak to authorizations.