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How to submit a medical authorization in AuthAccel (updated 5/2021)

There are three types of medical authorizations that can be submitted in AuthAccel: 1) Inpatient, 2) Service Request (Prior Auth), and 3) Medication.

A medication request is for drugs injected or infused in a medical setting. A pharmacy request is for medication that is prescribed to and self-administered by the patient.

Guidelines for working in AuthAccel

- AuthAccel currently performs best for providers with fewer than 2,000 Provider IDs attached to their Tax ID.
- Google Chrome is the preferred browser.
- Do not use browser navigation when working in AuthAccel.
- Work will not be saved if the system is exited prior to submitting a request.
- AuthAccel times out after 30 minutes of inactivity and will not save unsubmitted entries.
- Mandatory fields in AuthAccel are indicated with an asterisk (*****).
- Many drop-down lists offer predictive search. Click in the open field and begin typing to display a list of options that best match your entry.

Access AuthAccel from Provider Connection

1. Click **Authorizations** at the top of the homepage.
2. Click **Medical Authorization** from the blue navigation banner.
3. Select the appropriate Tax ID from the drop-down list.
4. Click **Go**.
5. AuthAccel opens in a new window.
    - To submit under a different Tax ID, close AuthAccel, return to the *Medical Authorizations* page in Provider Connection, and select the new Tax ID.

AuthAccel works differently by plan type. **Click the link below to view instructions for the appropriate plan type.**

- Commercial and FEP plans
- Medicare, Medi-Cal, and Cal Medi-Connect plans

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Below are step-by-step instructions for how to submit a medical authorization request in AuthAccel for a Commercial member. You can: 1) move through each section sequentially or 2) **CTRL + click** on a specific topic in the table of contents below.

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Determine if authorization is required

AuthAccel tells you when Blue Shield does or does not require authorization for a medical service. The system also tells you when authorization is delegated to another approver.

When either is the case, completing and submitting the request will result in an **inquiry**. You must complete the process and click **Submit** to secure an inquiry number. You can print the inquiry for your records.

- Determination if an authorization is or is not required by Blue Shield is made after you enter the procedure code(s).
  - If a request contains a code requiring authorization and a code that does not, it will submit as an authorization. However, you will receive a determination only on the code that requires authorization.
- Delegation alerts include the name and contact information for the appropriate authorizer. Based on the member's plan, they can display when you:
  - Enter member information
  - Select the ***Request Type** and/or the ***Place of Service** fields
  - Select the Inpatient **Admit Type**
  - Enter the primary diagnosis code or procedure code

Define the request

6. The *Search for Member* window displays.
7. Enter the member's ***First Name**, ***Last Name**, ***Date of Birth** (mm-dd-yyyy) and ***Member ID** (Nine numbers with or without the three-letter alpha-prefix **or** one letter plus eight numbers.)
8. Click **Search**. The *Member Search Results* window displays status for the current eligibility period.
   - Members with dual eligibility will display both plan options. Select the appropriate plan.
   - If the *Member Search Results* window displays "Member not found," check that all entries are correct and click **Search** again.
   - If the *Member Search Results* window displays without data, the member is NOT currently eligible.

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- To see past or future eligibility, click the **Show all Eligibility Records** checkbox. To close this window, re-click the checkbox.
- To print a PDF of the *Member Search Results* window, click the **Print** button located in the lower right corner.

9. Click **Select** in the left column. The member information populates at the top of the screen.
10. All authorizations default to standard urgency. If appropriate, click the **Expedited** radio button.
    - An *Attestation Regarding Expedited Review* window opens. Review information to ensure selection is appropriate. If not, re-click the **Standard** radio button.
11. Select the correct provider from the ***Requesting Provider** drop-down list. The list contains the Provider ID Number (PIN), the provider and/or facility name (if applicable), and location.
    - When more than 20 providers are linked to a Tax ID, AuthAccel will activate a **Provider Search** button. Click **Provider Search**.
        - The **Provider Search** window displays. Enter the **Blue Shield Provider ID** under which the authorization is being submitted.
            - If you don't know the Provider ID under which the authorization was submitted or under which you were linked to the authorization, try searching by one of the other search options in the window.
            - Because accounts are structured differently, you may need to test which search options work best for you.
        - Click **Search**, then click **Select** in the left column to select the appropriate entry.
        - The request will populate with the requesting provider information.
    - If the provider for which you are submitting the authorization is not in the ***Requesting Provider** drop-down list or is not presenting in the search, or if the provider information displays incorrectly, contact your Provider Connection Account Manager or Provider Services at Blue Shield **(800) 541-6652**.
        - You will need to fax or phone in the authorization until the update for this provider is completed.
12. Grayed-out fields populate based on the requesting provider selected from the ***Requesting Provider** drop-down list and cannot be edited.

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13. If your organization uses its own authorization tracking system, enter that number in the **Alternative Auth ID** field. It will be linked to the authorization upon submission.
14. Review the requesting provider's ***Phone Number** and ***Fax Number** fields for accuracy. Correct or enter if necessary.
15. Complete the **Contact Name** and **Contact Phone** fields with your information. If applicable, add a phone extension in the **Contact Name** field (ex., Jim Doe, ext. 2).
16. Select the **Yes** or **No** radio button for **Requesting Provider Same as Servicing Provider**. "No" is the default.
    - If the requesting provider is different from the servicing provider, information about the servicing provider must be entered in the *Servicing and Facility Providers* section for the authorization to submit.
    - If you change the **Requesting Provider Same as Servicing Provider** selection *after* entering diagnosis and/or procedure codes, you may need to reenter these codes.
17. Select the ***Request Type** from the drop-down list. There are three options:

If you select this ***Request Type:**	Complete these fields.
Inpatient	• ***Place of Service** and ***Bed Type** ▪ Select from the drop-down lists or type in the open fields. • ***Admit Date** ▪ Enter the date (mm-dd-yyyy) or select using the calendar. • ***Admit Type** and **Admit From** ▪ Select from the drop-down lists or type in the open fields.
Medication	• ***Place of Service** ▪ Select from the drop-down list or type in the open field.
Service Request (Prior Auth)	• ***Place of Service** ▪ Select from the drop-down list or type in the open field.

- You may receive a delegation message when you select ***Request Type**, ***Place of Service**, or inpatient **Admit Type**.
- If you change a ***Request Type**, ***Place of Service**, and/or inpatient ***Admit Type** field *after* entering diagnosis and/or procedure codes, you may need to reenter these codes.

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18. If the member has a Cal-MediConnect or PPO/POS (point of service) plan, this field presents: **Select below if the member is using their Alternate Benefit Type**. Use the drop-down list to select the primary plan.
    - If no selection is made, members with a Cal-MediConnect plan will default to Medicare for claims payment, and members with a PPO/POS plan will default to HMO.

Add servicing and/or facility provider(s)

19. If **No** is selected in the **Requesting Provider Same as Service Provider** field, information about the servicing provider must be entered in the *Servicing and Facility Provider Information* section. This section is also where to add information about a facility.
20. Click the **Add Servicing/Facility Provider** button.
21. The *Search for Servicing Provider or Facility* window displays.
22. Enter the servicing provider's or facility's **NPI** in the appropriate field.
23. Under **Participating**, click either **Yes** or **No** to indicate whether the servicing provider or facility is in network. "Yes" is the default.
    - **Tip:** If the system doesn't generate the desired servicing provider or facility, change this default to **No** and search again.
24. Select "Servicing Provider" or "Facility" from the ***Type** drop-down list.
25. Click **Search**. The search results display.
    - NPI is the most effective way to search. If you do not have the NPI number, search for a:
        - Servicing provider by entering the **State** and partial or full **First Name** and **Last Name**.
        - Facility by entering the **Organization** and **State**.
            - **Tip:** Enter an organization name that allows for a wider search (e.g., St Maximus vs. St Maximus Medical Center).
        - If too many results populate, click the **Show Additional Search Fields** button to refine your search.
        - Click the **Clear** button to remove search criteria from primary and additional search fields.
26. Click **Select** in the left column to select the correct entry.

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Medical prior authorization request continued…

27. The *Servicing/Facility Provider Fax Number* window presents. Enter the servicing provider or facility ***Fax Number** plus **Contact Name** and **Contact Phone** and click **Save**.
28. The servicing provider or facility information displays in the *Servicing and Facility Provider Information* section.
29. **TO ADD AN UNKNOWN PROVIDER**: If the search results do not return the desired servicing provider and/or facility, close the search window, and click the **Add Unknown Provider** button. The *Enter Servicing Provider or Facility Information* window displays.
    - Complete the fields with what you know. Note, ***NPI** and ***Fax** are required fields.
    - Select the ***Type** from the drop-down list.
    - Click **Save**. The information displays in the *Servicing and Facility Provider Information* section.
30. To remove a servicing provider or facility that you have entered, click the **Remove** button in the *Action* column.

*Add diagnosis

31. Under the **Diagnosis* section, click the **Add Primary Diagnosis** button.
32. The *ICD Search* window displays. Enter a complete or partial ICD-10 code or enter a principle diagnosis description.
    - Do not enter or select an ICD-10 code range (ex., R50-R69).
33. Click **Search**. The search results display.
34. Click **Select** in the left column to select the appropriate diagnosis from the options provided.
35. The diagnosis information displays in the **Diagnosis* table.
    - You may receive a delegation message here: View the **Status** column.
36. If necessary, click the **Add Diagnosis** button and follow the same process to add additional diagnoses.
    - Do not use the **Add Primary Diagnosis** button to add additional diagnoses as it will overwrite your initial entry.
37. To remove a diagnosis that you have entered, click the **Remove** button in the *Action* column.

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Medical prior authorization request continued…

*Add procedure – required for medication, service request and scheduled inpatient authorizations.

38. Under the **Procedure* section:
    - For inpatient requests, click the **Add Primary Procedure** button.
    - For medication and service requests, click the **Add Procedure** button.
39. The *CPT/HCPCS Search* window displays. Enter a complete or partial CPT/HCPCS code or enter a procedure description.
40. Click **Search**. The search results display.
41. Click **Select** in the left column to select the appropriate procedure from the options provided.
42. The *CPT/HCPCS Information* window displays.
43. View the **PA (Prior Authorization) Status** field to determine if the service requires authorization by Blue Shield or if it is delegated to another entity.
    - If an authorization is not required or is delegated, the system will change the request to an inquiry. Complete the remaining fields and click **Submit** to secure an inquiry number and print documentation.
44. Complete as many fields as possible with what is known about the procedure.

Field	Description/Instructions
Modifier 1 and 2 Description	Include modifiers when needed. To add, click the **magnifying glass**. Enter a complete or partial modifier code or enter a description. Click **Search**. The search results display. Click **Select** in the left column to select the appropriate modifier from the options provided.
***Quantity**	Enter the amount or number that best matches the request.
***Units**	Select the description that best aligns with the quantity.
Frequency	Select the number of occurrences that best aligns with the units. Use the drop-down list or click in the drop-down field and type.
Start and End Dates	The start date defaults to today's date, and the end date defaults to 120 days later. Use defaults or enter dates that best align with the request. • For labs: Enter the actual draw date in the **Start Date** field. • For inpatient: Enter the date entered in the **Admit Date** field in the **Start Date**.

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Medical prior authorization request continued…

Field	Description/Instructions
Short Description	The system populates a description based on the CPT/HCPCS code. Edit when using unlisted or miscellaneous (generic) codes. • For example, edit the K0108 (generic wheelchair accessory code) description to describe the exact accessory.
Requested Total Duration of Therapy	Select the duration from the drop-down list that best aligns with the quantity, units, and frequency. Select **Other** if the preferred duration is not a menu option, then enter a short description.

45. The procedure information displays in the **Procedure* table.
    - The **Status** column will repeat the information contained in the **PA Status** field from the *CPT/HCPCS Information* window.
46. If necessary, click the **Add Procedure** button and follow the same process to add additional procedures.
    - For inpatient requests, do not use the **Add Primary Procedure** button to add additional procedures as it will overwrite your initial entry.
47. To remove a procedure that you have entered, click the **Remove** button in the *Action* column.

Submit the authorization or inquiry

48. Click **Submit** at the bottom of the screen to submit the request.
    - The system displays an alert if required information is missing.
    - The system provides an **Inquiry Number** when an authorization is not required or is delegated. Note the number for your records and/or click **Print Inquiry**. The inquiry process is now complete.
49. **For medication requests**, the *SB 866 Prior Authorization Form* window displays. Complete the form and click **Submit**.
    - Documentation can be added by clicking **Add Documents**. Documentation can also be added after you close this window – see the *Add documentation* section below.
    - Click **Cancel** to close the *SB 866 Prior Authorization Form* window after you have completed all fields.

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50. If the authorization is:

Eligible for immediate approval	NOT eligible for immediate approval
The *MCG Authorization Request* window will display containing a Document Clinical Questionnaire. (There may be a short lag time.)	The *Add documentation* window will display.

Complete the Document Clinical Questionnaire if request is eligible for immediate approval

The purpose of the **Document Clinical Questionnaire** is to verify medical necessity for an authorization by providing clinical information that supports the codes submitted in the request. If the clinical information aligns with Blue Shield of California clinical policy, the authorization can immediately approve.

51. Click the **Document Clinical** button to launch the questionnaire. The components of the **Document Clinical Questionnaire** will include:
    A. Medical policy title.
    B. Indications (a list of questions or statements with checkboxes) for each code.
    C. Optional text boxes for clinical notes.
    D. Three dots (…) that indicate additional indications will open if you check the box.
    E. Hyperlinks to definitions and required documentation.
    F. Save button to save your entries. Prior to submitting, you can also 1) edit saved entries or 2) remove all saved entries to restart documentation.
    G. Cancel button to cancel the request.

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52. Click the **checkbox** next to each indication (statement or question) that applies to the patient. Leave the checkbox blank if the indication does not apply to the patient.
53. Depending on your answers, additional indications may present.
    - You may see multiple, nested statement/question blocks when an indication is followed by three dots (…).
54. When you have completed the questionnaire in full, click **Save**.
    - To edit entries after saving, click **Edit Documentation.** Click **Save** to save your changes.
    - To delete all saved entries and restart documentation, click **Remove Documentation**. Click **Save**.
55. If you have submitted more than one code requiring Blue Shield authorization, a **Document Clinical** button will present for the next code until all codes are addressed. Complete the questionnaire(s) and click **Save**.
    - If the same indication is attached to more than one code on the request, previous documentation for the indication will automatically populate for the other code(s). The following note will display: "*Refer to documentation of <previous code>.*"
    - To exit the **Document Clinical Questionnaire** without submitting, click **Cancel Request**. You will return to AuthAccel and the *Add Documentation* window. The authorization will no longer be eligible for immediate approval.
56. Click **Submit the Request**. The *MCG Authorization Request* window closes.

Add documentation

57. To add supporting documentation, click **Add Documents**. The *Upload Additional Document* window displays.
    - If the authorization is eligible for immediate approval, The *Add Documentation* window presents with the **Document Clinical Questionnaire(s)** (MCG files) attached. **Do not remove these attachments.**
58. To add supporting documentation, click **Add Documents**. The *Upload Additional Document* window displays.
    - There is no limit to the number or size of documents that can be attached to the request. Larger files will take longer to upload.
        - PDF is the preferred file type, but most file types are accepted.

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Medical prior authorization request continued…

59. Click **Choose File** to access documents on your computer.
60. Click a file to select it, then click **Open** and **Upload Document**. Repeat as necessary until all documentation is added.
61. Click **Submit**. The documents are now attached to the request.
    - Click **Choose File** to access documents on your computer.

Receive authorization status

62. The *Request Medical Prior Authorizations* window displays with either an "Approved" or "In Progress" *Authorization Status* as well as a *Reference#*, which is the unique searchable authorization number given to each request.
    - To access information related to an approved or in progress authorization, return to Provider Connection, click **Medical Authorization Status**, and launch AuthAccel's view status functionality.
63. Authorization entry is now complete. Click the **Create Auth for same member** or **Create Auth for different member** to submit another medical (i.e., inpatient, service request, or medication) authorization. Click the **X** in the upper right corner to close and exit the system.

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Below are step-by-step instructions for how to submit a medical authorization request in AuthAccel for a Medicare member. You can: 1) move through each section sequentially or 2) **CTRL + click** on a specific topic in the table of contents below.

Medicare, Medi-Cal, Cal MediConnect Member:

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Define the request

6. The *Search for Member* window displays.
7. Enter the member's ***First Name**, ***Last Name**, ***Date of Birth** (mm-dd-yyyy) and ***Member ID** (Nine numbers with or without the three-letter alpha-prefix **or** one letter plus eight numbers.)
8. Click **Search**. The *Member Search Results* window displays status for the current eligibility period.
    - Members with dual eligibility will display both plan options. Select the appropriate plan.
    - If the *Member Search Results* window displays "Member not found," check that all entries are correct and click **Search** again.
    - If the *Member Search Results* window displays without data, the member is NOT currently eligible.
    - To see past or future eligibility, click the **Show all Eligibility Records** checkbox. To close this window, re-click the checkbox.
    - To print a PDF of the *Member Search Results* window, click the **Print** button located in the lower right corner.
9. Click **Select** in the left column. The member information populates at the top of the screen.
10. All authorizations default to standard urgency. If appropriate, click the **Expedited** radio button.
    - An *Attestation Regarding Expedited Review* window opens. Review information to ensure selection is appropriate. If not, re-click the **Standard** radio button.

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Medical prior authorization request continued…

11. Select the correct provider from the ***Requesting Provider** drop-down list. The list contains the Provider ID Number (PIN), the provider and/or facility name (if applicable), and location.
    - When more than 20 providers are linked to a Tax ID, AuthAccel will activate a **Search** button. Click **Search**.
        - The **Provider Search** window displays. Enter the **Blue Shield Provider ID** under which the authorization is being submitted.
            - If you don't know the Provider ID under which the authorization was submitted or under which you were linked to the authorization, try searching by one of the other search options in the window.
            - Because accounts are structured differently, you may need to test which search options work best for you.
        - Click **Search**, then click **Select** in the left column to select the appropriate entry.
        - The request will populate with the requesting provider information.
    - If the provider for which you are submitting the authorization is not in the ***Requesting Provider** drop-down list or is not presenting in the search, or if the provider information displays incorrectly, contact your Provider Connection Account Manager or Provider Services at Blue Shield **(800) 541-6652** or Blue Shield Promise **(800) 468-9935**.
        - You will need to fax or phone in the authorization until the update for this provider is completed.
12. Grayed-out fields populate based on the requesting provider selected from the ***Requesting Provider** drop-down list and cannot be edited.
13. If your organization uses its own authorization tracking system, enter that number in the **Alternative Auth ID** field. It will be linked to the authorization upon submission.
14. Review the requesting provider's ***Phone Number** and ***Fax Number** fields for accuracy. Correct or enter if necessary.
15. Complete the **Contact Name** and **Contact Phone** fields with your information. If applicable, add a phone extension in the **Contact Name** field (ex., John Doe, ext. 32).

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16. Select the **Yes** or **No** radio button for **Requesting Provider Same as Servicing Provider**. "No" is the default.
    - If the requesting provider is different from the servicing provider, information about the servicing provider must be entered in the *Servicing and Facility Providers* section for the authorization to submit.
17. Select the ***Request Type** from the drop-down list. There are three options:

If you select this ***Request Type:**	Complete these fields.
Inpatient	• ***Place of Service** and ***Bed Type** ▪ Select from the drop-down lists or type in the open fields. • ***Admit Date** ▪ Enter the date (mm-dd-yyyy) or select using the calendar. • ***Admit Type** and **Admit From** ▪ Select from the drop-down lists or type in the open fields.
Medication	• ***Place of Service** ▪ Select from the drop-down list or type in the open field.
Service Request (Prior Auth)	• ***Place of Service** ▪ Select from the drop-down list or type in the open field.

    - If you change a ***Request Type**, ***Place of Service**, and/or inpatient ***Admit Type** field *after* entering diagnosis and/or procedure codes, you may need to reenter these codes.
18. If the member has a Cal-MediConnect or PPO/POS (point of service) plan, this field presents: **Select below if the member is using their Alternate Benefit Type**. Use the drop-down list to select the primary plan.
    - If no selection is made, members with a Cal-MediConnect plan will default to Medicare for claims payment, and members with a PPO/POS plan will default to HMO.

Add servicing and/or facility provider(s)

19. If **No** is selected in the **Requesting Provider Same as Service Provider** field, information about the servicing provider must be entered in the *Servicing and Facility Provider Information* section. This section is also where to add information about a facility.
20. Click the **Add Servicing/Facility Provider** button.

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21. The *Search for Servicing Provider or Facility* window displays.
22. Enter the servicing provider's or facility's **NPI** in the appropriate field.
23. Under **Participating**, click either **Yes** or **No** to indicate whether the servicing provider or facility is in network. "Yes" is the default.
    - **Tip:** If the system doesn't generate the desired servicing provider or facility, change this default to **No** and search again.
24. Select "Servicing Provider" or "Facility" from the ***Type** drop-down list.
25. Click **Search**. The search results display.
    - NPI is the most effective way to search. If you do not have the NPI number, search for a:
      - Servicing provider by entering the **State** and partial or full **First Name** and **Last Name**.
      - Facility by entering the **Organization** and **State**.
        - **Tip:** Enter an organization name that allows for a wider search (e.g., St Maximus vs. St Maximus Medical Center).
      - If too many results populate, click the **Show Additional Search Fields** button to refine your search.
      - Click the **Clear** button to remove search criteria from primary and additional search fields.
26. Click **Select** in the left column to select the correct entry.
27. The *Servicing/Facility Provider Fax Number* window presents. Enter the servicing provider or facility ***Fax Number** plus **Contact Name** and **Contact Phone** and click **Save**.
28. The servicing provider or facility information displays in the *Servicing and Facility Provider Information* section.
29. **TO ADD AN UNKNOWN PROVIDER**: If the search results do not return the desired servicing provider and/or facility, close the search window, and click the **Add Unknown Provider** button. The *Enter Servicing Provider or Facility Information* window displays.
    - Complete the fields with what you know. Note, ***NPI** and ***Fax** are required fields.
    - Select the ***Type** from the drop-down list.
    - Click **Save**. The information displays in the *Servicing and Facility Provider Information* section.

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Medical prior authorization request continued…

30. To remove a servicing provider or facility that you have entered, click the **Remove** button in the *Action* column.

*Add diagnosis

31. Under the **Diagnosis* section, click the **Add Primary Diagnosis** button.
32. The *ICD Search* window displays. Enter a complete or partial ICD-10 code or enter a principle diagnosis description.
    - Do not enter or select an ICD-10 code range (ex., R50-R69).
33. Click **Search**. The search results display.
34. Click **Select** in the left column to select the appropriate diagnosis from the options provided.
35. The diagnosis information displays in the **Diagnosis* table.
36. If necessary, click the **Add Diagnosis** button and follow the same process to add additional diagnoses.
    - Do not use the **Add Primary Diagnosis** button to add additional diagnoses as it will overwrite your initial entry.
37. To remove a diagnosis that you have entered, click the **Remove** button in the *Action* column.

*Add procedure – required for medication, service request and scheduled inpatient authorizations.

38. Under the **Procedure* section:
    - For inpatient requests, click the **Add Primary Procedure** button.
    - For medication and service requests, click the **Add Procedure** button.
39. The *CPT/HCPCS Search* window displays. Enter a complete or partial CPT/HCPCS code or enter a procedure description.
40. Click **Search**. The search results display.
41. Click **Select** in the left column to select the appropriate procedure from the options provided.
42. The *CPT/HCPCS Information* window displays.

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43. Complete as many fields as possible with what is known about the procedure.

Field	Description/Instructions
Modifier 1 and 2 Description	Include modifiers when needed. To add, click the **magnifying glass**. Enter a complete or partial modifier code or enter a description. Click **Search**. The search results display. Click **Select** in the left column to select the appropriate modifier from the options provided.
***Quantity**	Enter the amount or number that best matches the request.
***Units**	Select the description that best aligns with the quantity.
Frequency	Select the number of occurrences that best aligns with the units. Use the drop-down list or click in the drop-down field and type.
Start and End Dates	The start date defaults to today's date, and the end date defaults to 120 days later. Use defaults or enter dates that best align with the request. • For labs: Enter the actual draw date in the **Start Date** field. • For inpatient: Enter the date entered in the **Admit Date** field in the **Start Date**.
Short Description	The system populates a description based on the CPT/HCPCS code. Edit when using unlisted or miscellaneous (generic) codes. • For example, edit the K0108 (generic wheelchair accessory code) description to describe the exact accessory.
Requested Total Duration of Therapy	Select the duration from the drop-down list that best aligns with the quantity, units, and frequency. Select **Other** if the preferred duration is not a menu option, then enter a short description.

44. The procedure information displays in the **Procedure* table.
45. If necessary, click the **Add Procedure** button and follow the same process to add additional procedures.
    - For inpatient requests, do not use the **Add Primary Procedure** button to add additional procedures as it will overwrite your initial entry.
46. To remove a procedure that you have entered, click the **Remove** button in the *Action* column.

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Medical prior authorization request continued…

Submit the authorization

47. Click **Submit** at the bottom of the screen to submit the request.
    - The system displays an alert if required information is missing.
48. **For medication requests**, the *SB 866 Prior Authorization Form* window displays. Complete the form and click **Submit**.
    - Documentation can be added by clicking **Add Documents**. Documentation can also be added after you close this window – see the *Add documentation* section below.
    - Click **Cancel** to close the *SB 866 Prior Authorization Form* window after you have completed all fields.

Add documentation

49. To add supporting documentation, click **Add Documents**. The *Upload Additional Document* window displays.
    - There is no limit to the number or size of documents that can be attached to the request. Larger files will take longer to upload.
        - PDF is the preferred file type, but most file types are accepted.
50. Click **Choose File** to access documents on your computer.
51. Click a file to select it, then click **Open** and **Upload Document**. Repeat as necessary until all documentation is added.
52. Click **Submit**. The documents are now attached to the request.

Receive authorization status

53. The *Request Medical Prior Authorizations* window displays with an *Authorization Status of* "In Progress" as well as a *Reference #*, which is the unique searchable authorization number given to each request.
    - To access information related to the authorization, return to Provider Connection, click **Medical Authorization Status**, and launch AuthAccel's view status functionality.
54. Authorization entry is now complete. Click the **Create Auth for same member** or **Create Auth for different member** to submit another medical (i.e., inpatient, service request, or medication) authorization. Click the **X** in the upper right corner to close and exit the system.

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