

How to submit a medical authorization in AuthAccel (updated 1/2026)

There are six types of medical authorizations that can be submitted in AuthAccel:

1) Inpatient, 2) BH Inpatient, 3) Service Request (Prior Auth), 4) BH Service Request, 5) Medication, and 6) BH Medication. A medication request is for drugs injected or infused in a medical setting. BH = Behavioral Health.

Guidelines for working in AuthAccel

- You must be logged into Provider Connection to access 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. Log into [Provider Connection](#).
2. Click **Authorizations** at the top of the homepage.
3. Click **Medical authorization** from the menu.
4. Select the appropriate Tax ID from the drop-down list.
5. Click **Go**.
6. 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.



Medical prior authorization request continued...

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

- [Commercial and FEP plans](#)
- [Medicare and Medi-Cal plans](#)

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) **click** on a specific topic in the table of contents below.

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Medical prior authorization request continued...

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

7. The *Search for Member* window displays.
8. 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.)
9. 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.

Medical prior authorization request continued...

- To print a PDF of the *Member Search Results* window, click the **Print** button located in the lower right corner.
10. Click **Select** in the left column. The member information populates at the top of the screen.
 11. 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. Click **Provider Search**. The **Referring/Prescribing/Ordering Provider Search* window displays.
 - To search, enter the **Provider ID** or **NPI** or **Fed Tax ID** or **(First Name and Last Name and State)** or **(State and Organization)**.
 - Click **Search**, then click **Select** in the left column to select the appropriate entry.
 - The main screen will populate with the **Referring/Prescribing/Ordering Provider* information.
 - If you cannot locate the provider via the search, click **Cancel**, then click the **Unknown Provider** checkbox on the main screen. Enter the provider's demographic information in all required fields.
 12. 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.
 13. Review the provider's ***Phone Number** and ***Fax Number** fields for accuracy. Correct or enter if necessary.
 14. 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).

Medical prior authorization request continued...

15. Select the ***Request Type** from the drop-down list. There are six options:

If you select this *Request Type :	Complete these fields.
Inpatient or BH Inpatient	<ul style="list-style-type: none"> • *Place of Service and *Bed Type <ul style="list-style-type: none"> ▪ Select from the drop-down lists or type in the open fields. • *Admit Date <ul style="list-style-type: none"> ▪ Enter the date (mm-dd-yyyy) or select using the calendar. • *Admit Type and Admit From <ul style="list-style-type: none"> ▪ Select from the drop-down lists or type in the open fields.
Medication or BH Medication	<ul style="list-style-type: none"> • *Place of Service <ul style="list-style-type: none"> ▪ Select from the drop-down list or type in the open field.
Service Request (Prior Auth) or BH Service Request	<ul style="list-style-type: none"> • *Place of Service <ul style="list-style-type: none"> ▪ 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.

16. 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.

17. Select the **Yes** or **No** radio button for **Referring/Prescribing/Ordering Provider Same as Servicing/Billing Provider/Vendor/Lab**. "No" is the default.

- If you change the *Referring/Prescribing/Ordering Provider Same as Servicing/Billing Provider/Vendor/Lab* selection **after** entering diagnosis and/or procedure codes, you may need to reenter these codes.

Medical prior authorization request continued...

Add servicing/billing: provider/vendor/lab and facility information

18. If **No** is selected in the *Referring/Prescribing/Ordering Provider Same as Servicing/Billing Provider/Vendor/Lab* field, provider information must be entered in this section. This section is also where to add information about a facility.
19. Click the **Add Servicing/Billing: Provider/Vendor/Lab/Facility** button.
20. The search window displays.
21. Enter the **Provider ID** or **NPI** or **Fed Tax ID** or **(First Name and Last Name and State)** or **(State and Organization)**.
22. Under **Participating**, click either **Yes** or **No** to indicate whether the provider (vendor, lab) or facility is in network. "Yes" is the default.
 - **Tip:** If the system doesn't generate the desired response, change this default to **No** and search again.
23. Select "Servicing Provider" or "Facility" from the ***Type** drop-down list.
24. Click **Search**. The search results display.
 - If too many results populate, click the **Show Additional Search Fields** button to refine your search.
25. Click **Select** in the left column to select the appropriate entry.
26. 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**.
27. The provider or facility information displays in the *Servicing/Billing Provider/Vendor/Lab and Facility* section.
28. **TO ADD AN UNKNOWN PROVIDER:** If the search results do not return the desired result, 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/Billing Provider/Vendor/Lab and Facility* section.
29. To remove an entry, click the **Remove** button in the *Action* column.

Medical prior authorization request continued...

***Add diagnosis**

30. Under the **Diagnosis* section, click the **Add Primary Diagnosis** button.
31. 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).
32. Click **Search**. The search results display.
33. Click **Select** in the left column to select the appropriate diagnosis from the options provided.
34. The diagnosis information displays in the **Diagnosis* table.
 - You may receive a delegation message here: View the **Status** column.
35. 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.
36. 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.**

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

Medical prior authorization request continued...

42. 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.

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. <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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.

- The **Status** column will repeat the information contained in the **PA Status** field from the *CPT/HCPCS Information* window.

Medical prior authorization request continued...

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.

Submit the authorization or inquiry

47. 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.

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 **Close** to close the *SB 866 Prior Authorization Form* window after you have completed all fields.

49. If the authorization is:

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

Medical prior authorization request continued...

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.

50. 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.

Procedure Code: E0784 (CPT/HCPCS)
Requested Units: 1
Description: External ambulatory infusion pump insulin

A BSC1.03 - BSC COMM External Insulin Infusion Pump - (AC)

The procedure is/was needed for appropriate care of the patient because of ...

☒ A first-time external insulin infusion pump with or without continuous glucose monitoring (CGM), low glucose suspend or automatic adjustment of basal insulin rate capability, for insulin-requiring diabetic patients, is indicated by ... (Required Documentation for Policy 1.03)

☐ The device requested is age appropriate as approved by the U.S. Food and Drug Administration (FDA) (C)

☐ Documented clinical presentation is indicated by ...

☐ Documented diabetes management for first time pump users is indicated by ...

☐ An external insulin infusion pump for preconception or pregnant diabetic women is indicated by ... (Required Documentation for Policy 1.03)

☐ Replacement of an external insulin infusion pump is indicated by ... (Required Documentation for Policy 1.03)

F Save **G** Cancel

51. 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.

52. Depending on your answers, additional indications may present.

- You may see multiple, nested statement/question blocks when an indication is followed by three dots (...).

Medical prior authorization request continued...

53. 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**.

54. 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.

55. Click **Submit the Request**. The *MCG Authorization Request* window closes.

Add documentation

56. 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.**

57. 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.

58. Click **Choose File** to access documents on your computer.

59. Click a file to select it, then click **Open** and **Upload Document**. Repeat as necessary until all documentation is added.

60. Click **Submit**. The documents are now attached to the request.

- Click **Choose File** to access documents on your computer.



Medical prior authorization request continued...
Receive authorization status

61. 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.
62. 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.

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) **click** on a specific topic in the table of contents below.

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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.
11. Click **Provider Search**. The **Referring/Prescribing/Ordering Provider Search* window displays.
 - To search, enter the **Provider ID** or **NPI** or **Fed Tax ID** or **(First Name and Last Name and State)** or **(State and Organization)**.
 - Click **Search**, then click **Select** in the left column to select the appropriate entry.
 - The main screen will populate with the **Referring/Prescribing/Ordering Provider* information.

Medical prior authorization request continued...

- If you cannot locate the provider via the search, click **Cancel**, then click the **Unknown Provider** checkbox on the main screen. Enter the provider's demographic information in all required fields.
12. 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.
13. Review the requesting provider's ***Phone Number** and ***Fax Number** fields for accuracy. Correct or enter if necessary.
14. 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).
15. Select the ***Request Type** from the drop-down list. There are six options:

If you select this *Request Type:	Complete these fields.
Inpatient or BH Inpatient	<ul style="list-style-type: none"> • *Place of Service and *Bed Type <ul style="list-style-type: none"> ▪ Select from the drop-down lists or type in the open fields. • *Admit Date <ul style="list-style-type: none"> ▪ Enter the date (mm-dd-yyyy) or select using the calendar. • *Admit Type and Admit From <ul style="list-style-type: none"> ▪ Select from the drop-down lists or type in the open fields.
Medication or BH Medication	<ul style="list-style-type: none"> • *Place of Service <ul style="list-style-type: none"> ▪ Select from the drop-down list or type in the open field.
Service Request (Prior Auth) or BH Service Request	<ul style="list-style-type: none"> • *Place of Service <ul style="list-style-type: none"> ▪ 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.

Medical prior authorization request continued...

16. 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.

17. Select the **Yes** or **No** radio button for **Referring/Prescribing/Ordering Provider Same as Servicing/Billing Provider/Vendor/Lab**. "No" is the default.

- If you change the *Referring/Prescribing/Ordering Provider Same as Servicing/Billing Provider/Vendor/Lab* selection **after** entering diagnosis and/or procedure codes, you may need to reenter these codes.

Add servicing and/or facility provider(s)

18. If **No** is selected in the *Referring/Prescribing/Ordering Provider Same as Servicing/Billing Provider/Vendor/Lab* field, provider information must be entered in this section. This section is also where to add information about a facility.

19. Click the **Add Servicing/Billing: Provider/Vendor/Lab/Facility** button.

20. The search window displays.

21. Enter the **Provider ID** or **NPI** or **Fed Tax ID** or **(First Name and Last Name and State)** or **(State and Organization)**.

22. 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.

23. Select "Servicing Provider" or "Facility" from the ***Type** drop-down list.

24. Click **Search**. The search results display.

- If too many results populate, click the **Show Additional Search Fields** button to refine your search.

25. Click **Select** in the left column to select the appropriate entry.

- 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.

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 provider or facility information displays in the *Servicing/Billing Provider/Vendor/Lab and Facility* section.

29. **TO ADD AN UNKNOWN PROVIDER:** If the search results do not return the desired result, 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/Billing Provider/Vendor/Lab and Facility* section.

30. To remove an entry, 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.

- a. 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.

Medical prior authorization request continued...

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

38. Under the **Procedure* section:

- b. For inpatient requests, click the **Add Primary Procedure** button.
- c. 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. 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. <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> For example, edit the K0108 (generic wheelchair accessory code) description to describe the exact accessory.

Medical prior authorization request continued...

Field	Description/Instructions
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.

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.

Medical prior authorization request continued...

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.