# Prior Authorization Support Letter Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

**A prior authorization support letter** is a narrative letter a treating clinician sends to a health plan to justify why a mental health service should be authorized before it is delivered, or continued. It maps the diagnosis, severity, functional impairment, and treatment history to the plan's medical-necessity criteria. Many plans do not require prior authorization for routine outpatient therapy; it is most often needed for testing, higher levels of care, or plans that authorize therapy in blocks.

**1. Recipient & identifiers** who it goes to, and the member and request IDs

**Do:** address it to the plan's utilization management or behavioral health prior-auth unit; open with member name, DOB, member ID, group #, the exact code(s) and units or dates, and the prior authorization # for a continuation.

**Pitfall:** sending it to general claims, or omitting the member ID or exact units, which stalls the request at intake.

**2. Diagnosis** the coded anchor for the request

**Do:** give the ICD-10 code(s) that support the requested service.

**Pitfall:** treating the diagnosis code as the justification; the code anchors the request, the impairment justifies it.

**3. Clinical picture & severity** symptoms with measures

**Do:** state current symptoms with a dated, validated measure (PHQ-9, GAD-7, PCL-5) and the course over time.

**Pitfall:** adjectives without measures; a dated score carries more weight than the word "severe".

**4. Functional impairment** the effect on daily life

**Do:** describe the concrete impact on work, school, relationships, self-care, and safety.

**Pitfall:** leaving impairment out; medical necessity turns on function, not symptoms alone.

**5. Treatment history & response** what has been tried

**Do:** summarize prior and current treatment, the response so far, and why a lower level of care is insufficient.

**Pitfall:** no treatment history, so the reviewer cannot see why the requested service is the right next step.

**6. Requested service & medical necessity** the ask, mapped to the plan's criteria

**Do:** name the exact service, frequency, and duration or level of care, map it to the plan's criteria (MCG, InterQual, ASAM, LOCUS), state the risk if it is not authorized, and offer a peer-to-peer.

**Pitfall:** an open-ended request; name the units and the dates.

## Before you send

- [ ] Member ID, exact code(s), units, and dates are all stated
- [ ] Severity documented with a dated, validated measure
- [ ] Functional impairment tied to the requested service
- [ ] Treatment history shows why a lower level of care is insufficient
- [ ] Mapped to the plan's medical-necessity criteria (MCG, InterQual, ASAM, LOCUS)
- [ ] Peer-to-peer offered; signed with credentials and NPI

## Drafting with AI

Capture the essentials: diagnosis and codes, current measure scores, functional impairment, what has been tried and the response, and the exact service, units, and dates requested.

> *"Draft a prior authorization support letter for 12 sessions of 90837 for recurrent MDD, PHQ-9 12, partial response, on a graduated return to work."*

**Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.**

| 400–700 words | 15–30 min by hand | Before a service, or to extend one | Health plan reviewer |
|---|---|---|---|
| typical length | clinical team estimate | when it's written | who reads it |

Full guide, sample letter, and compliance notes:
**bastiongpt.com/template/prior-authorization-letter**

**BastionGPT** drafts prior authorization letters from a few clinical details. Free 7-day trial.

# Prior Authorization Support Letter Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Practice letterhead: clinician name, credentials, license #, NPI, address, phone, fax

Date: To (plan / UM dept):

**RE: Prior authorization request ☐ initial ☐ continued**

Member name: Date of birth:

Member / policy ID: Group #:

Requested service / code:

Units / frequency / dates: Prior authorization # (continuation):

Dear Utilization Reviewer,

**Diagnosis (ICD-10)**

Code(s) and description that support the requested service

**Clinical presentation and severity**

Current symptoms, validated measure scores with dates (PHQ-9, GAD-7, PCL-5), onset and course

**Functional impairment**

Impact on work or school, relationships, self-care, safety

**Treatment history and response**

Prior and current treatment, medications, response, why a lower level of care is insufficient

**Requested service and medical necessity**

Exact service, frequency, duration or level of care, mapped to the plan's criteria, and the risk if not authorized. Offer a peer-to-peer.

Clinician signature / credentials / license # / NPI: Supervisor co-signature (if required):

Full guide, sample letter, and compliance notes:
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