Prior Authorization Request Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

A prior authorization request (precertification; concurrent review when care continues) is the clinical justification packet a provider submits to a health plan to get a mental health service approved before it starts or continues. Staff or the clinician assemble it from the record: diagnosis, symptom severity, functional impairment, treatment history, risk, and a plan with measurable goals. No universal form exists; each payer or carve-out vendor sets its own.

Member, provider, and service header state the request in billing terms
Do: member ID and plan, the BH carve-out vendor if one runs the benefit, provider license and NPI, CPT codes, units, dates.
Pitfall: authorization from the medical plan when a carve-out runs the benefit; the wrong entity's number does not bind.

Diagnosis code plus name
Do: the specific ICD-10-CM code the record supports, written as code plus name.
Pitfall: a Z-code or rule-out diagnosis standing alone; reviewers treat both as failing to anchor medical necessity.

Symptom severity and functional impairment scores plus this week's function
Do: current symptoms with severity, measure scores (PHQ-9, GAD-7), and what the client cannot do: work, school, self-care.
Pitfall: adjectives with no function. "Severe anxiety" approves nothing; "missed three of five workdays" is defensible.

Level-of-care justification write to the criteria
Do: argue this setting and intensity against the set the reviewer scores: LOCUS, CALOCUS-CASII, ASAM, InterQual, or MCG.
Pitfall: asserting the level instead of scoring it; the reviewer is completing a criteria worksheet, so write to it.

Treatment history and prior response what was tried, what happened
Do: prior episodes, medication trials, earlier therapy, partial responses, and the failed alternatives behind this request.
Pitfall: omitting response so far; measured progress plus remaining impairment is the whole continued-care argument.

Risk factors stated plainly, either way
Do: current risk status stated plainly, either way, with protective factors and the monitoring plan.
Pitfall: silence on risk; a packet that never mentions it invites the reviewer to assume it was never assessed.

Treatment plan, goals, and requested course make the math match
Do: measurable goals tied to the impairments above, the interventions for each, and the request restated as plan arithmetic.
Pitfall: vague, untracked goals ("improve coping skills") with no baseline or target: a classic documentation failure.

Urgency choose the clock deliberately
Do: standard or expedited, chosen on the clinical picture; expedited review is 72 hours by law on most regulated plan types.
Pitfall: filing routine when delay risks serious harm; the standard clock runs 7 to 15 days, and only the flag shortens it.

Before it goes out

- [ ] Diagnosis is a specified code with severity, no rule-out
- [ ] Scores dated with direction; function stated concretely
- [ ] Level of care scored against the named criteria set
- [ ] Prior response quantified; step-down or end point named
- [ ] CPT codes, units, frequency, and dates match the plan
- [ ] Filed before the current authorization runs out

Drafting with AI

Bring the treatment plan, recent notes, current scores, and the payer's criteria set; the packet mirrors what reviewers score.

> *"Draft a concurrent prior auth request: F33.1, PHQ-9 19 to 12 over 14 sessions, LOCUS outpatient, 12 more weekly 90834 from 08/11: …"*

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

300 to 600 words	20 to 45 min by hand	Before care · at renewal	UR staff · peer reviewers
plus attachments	clinical team estimate	when the plan gates it	who reads it

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

BastionGPT drafts prior auth packets from your notes. Free 7-day trial.

Prior Authorization Request Template

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

Member / client: | ID: | DOB:

Plan: | BH carve-out vendor (if any):

Provider (name / credentials / license): | NPI: | Phone / fax / portal:

Requested service

State the request in billing terms; the eventual claims must mirror these entries

CPT code(s): | Units: | Frequency: | Start date: | End date:

Request type: ☐ Initial request ☐ Concurrent / continued-stay review

Urgency: ☐ Standard ☐ Expedited (delay risks serious harm)

Diagnosis

Specific ICD-10-CM code plus name · no Z-code or rule-out standing alone

Severity and functional impairment

Scores with dates · this week's function: work, school, relationships, self-care

PHQ-9: | GAD-7: | Other measure / score:

Level-of-care justification

Score against the named criteria set: LOCUS / CALOCUS-CASII / ASAM / plan criteria (InterQual, MCG)

Treatment history and prior response

Prior episodes · medication trials · earlier therapy · measured response to treatment so far

Risk factors

Current status stated either way · protective factors · monitoring plan

Treatment plan and goals

Measurable goals with baseline and target · interventions · requested frequency and duration

Attachments: ☐ treatment plan ☐ recent progress note ☐ score sheet ☐ medical necessity letter

Clinician signature / credentials: | Date:

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

BastionGPT drafts prior auth packets from your notes. Free 7-day trial.