



Preauthorization FAQ for employees of Allentown School District

What is preauthorization?

Some healthcare services need to be approved by your health plan before you receive them. This process is called preauthorization.

Preauthorization helps ensure you get the right care — at the right time — from trusted providers. It supports high-quality, cost-effective treatment that meets your specific needs.

When do I need preauthorization?

Preauthorization is required for some medical and behavioral health services and all non-emergency inpatient hospital stays.

A current list of services is available at [CapBlueCross.com/preauthorization](https://www.CapBlueCross.com/preauthorization) and is updated regularly. You can also call the Member Services number on the back of your ID card (TTY: 711).

What if I see an in-network provider in Capital's service area?

If you see an in-network provider, they'll handle the preauthorization process for you.

Be sure to ask your provider if preauthorization is needed and if it's been submitted for services they recommend.

What if I see a Blue Card or out-of-network provider?

- Blue Card providers are those in other Blue networks outside our service area. They are not required to request preauthorization for outpatient care on your behalf. They are required to notify us within two business days of hospital admission for inpatient care.
- Out-of-network providers, even if they are in our service area, are not required to request preauthorization for any care on your behalf.

If you see a Blue Card or out-of-network provider, the provider may handle the preauthorization process for you. If they don't, you'll need to submit a preauthorization request yourself using the preauthorization form in your secure account at [CapBlue.com/preauthorization-form](https://www.CapBlue.com/preauthorization-form). Find in-network providers at [CapBlueCross.com/finder](https://www.CapBlueCross.com/finder).

You are ultimately responsible for getting the required approval before you receive a service that requires preauthorization.

What happens when the request is submitted?

When we receive your preauthorization request, our team of doctors and healthcare professionals review it. They evaluate the request using industry standards, best practices, and other criteria to ensure the care is appropriate and effective for your needs.

Capital Blue Cross may work with other organizations to assist with the administration of our benefits programs for services.

Once the review is complete, a letter will be mailed to your home explaining the decision and what comes next.

If you have questions, call Member Services at the number on the back of your ID card (TTY: 711).

How long does it take to review a preauthorization request?

- Non-urgent preservice requests – up to 15 calendar days.
- Urgent preservice requests – within 72 hours.
- Urgent concurrent requests (while in the hospital) – within 24 hours.
- Non-urgent concurrent requests – within 72 hours.

My provider submitted a preauthorization request, and I haven't heard about the decision yet. How do I check the request?

You should always check your preauthorization status before the scheduled date of your service by calling Member Services at the number on the back of your ID card (TTY: 711).

Remember: to avoid unexpected costs, be sure a preauthorization request is submitted if it's required. If it's not in place before your service, your claim could be denied, and you might have to cover the cost.

My preauthorization request was denied. What should I do?

Call Member Services at the number on the back of your ID card (TTY: 711) to learn about your options. If you receive a denial, it will also include instructions on how to submit an appeal and what steps to take next.

What about the emergency room. Is preauthorization required?

No. Preauthorization isn't needed for services provided in a hospital emergency room.