SANFORD
HEALTH PLAN

Prior Authorization FAQs

For Sanford Health Plan Providers

Why is SHP requiring electronic prior authorization?

To better serve our members and providers through expediting workflows and increased transparency of the process.

When will electronic prior authorization process be required?

SHP will be requiring submission of prior authorizations electronically effective Oct. 1, 2020.

Where will I submit electronic prior authorization?

- **Internal Sanford Epic Users:** Please submit authorization requests via the current internal Epic process.
- **External Providers:** Please submit authorization requests via Provider Portal at **sanfordhealthplan.com**.

How will I submit electronic prior authorization?

There will be two different options depending on whether you are an internal (Sanford) Epic user. The internal (Sanford) Epic process is optimal for efficiency.

- **Internal Sanford Epic Users:** Please submit authorization requests via the current internal Epic process.
- **External Providers:** Please submit authorization requests via Provider Portal at **sanfordhealthplan.com**.

How will I know if my authorization has been approved?

The authorization status will be available in real time via the Provider Portal or Internal EPIC view.

Who do I contact with questions about how to file an electronic prior authorization?

Please contact Provider Relations at (800) 601-5086.

What if I am unable to submit electronically?

While we require electronic submission for optimal turnaround and status determination in real time, we understand urgent situations arise. If you feel you need to speak with someone, please contact our Utilization Management department to submit via phone at (800) 805-7938.

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What if I have a retrospective authorization request?

Starting on January 1, 2021, providers will be responsible for obtaining prior authorization per the Member's Benefit Plan documents (COI, COC, etc.). If the request was not obtained before the service was rendered, the provider has 60 days from date of service to submit a Retro Authorization Request through the UM or Pharmacy department by means of the provider portal. Retro is defined by the plan as a request for approval filed after the service was completed. If the Retro request is greater than 60 days from date of service, no further action will be taken by the plan. The provider will also not be able to submit a reconsideration after this time, if the claim is on the prior authorization list.

My retrospective authorization has been approved; what are next needed steps?

Resubmit claim with approved authorization number.