# SOP Template: Documentation of Referral Requirements and Pre-Authorization

This SOP details the process for **documentation of referral requirements and pre-authorization**, including identifying situations requiring referrals, obtaining necessary approvals, completing required forms, verifying insurance coverage, communicating with referral providers, and maintaining accurate records. The objective is to ensure timely and compliant processing of referrals to optimize patient care and administrative efficiency.

## 1. Purpose

To outline the standardized procedure for documenting referral requirements and obtaining pre-authorization when required, in order to ensure compliance, optimize patient care, and streamline administrative workflows.

## 2. Scope

This SOP applies to all clinical and administrative staff involved in patient referrals and pre-authorization processes.

## 3. Responsibilities

- **Referring Provider:** Identifies need for referral and provides necessary clinical information.
- **Administrative Staff:** Manages insurance verification, documentation, form completion, and communication with referral recipients.
- **Insurance Coordinator:** Facilitates obtaining pre-authorization from payer as needed.

## 4. Definitions

- **Referral:** The process of directing a patient to another provider or specialist for additional care.
- **Pre-authorization (Prior Authorization):** Advance approval obtained from the payer for a specific service, procedure, or referral.

## 5. Procedure

1. **Identify Referral Requirement**
    - Assess patient's clinical need for external consultation, treatment, or diagnostic service.
    - Review payer policies and plan requirements regarding referrals and pre-authorization.
2. **Verify Insurance Coverage**
    - Confirm patient's insurance plan and coverage details.
    - Determine if referral/pre-authorization is required for the specific service or provider.
3. **Obtain Pre-Authorization**
    - Complete and submit required pre-authorization forms/documentation to the insurance payer.
    - Attach supporting clinical documentation as needed.
    - Follow up with payer until decision is received.
4. **Document Actions**
    - Record all communications, approvals, and reference numbers in the patient's electronic health record (EHR).
    - Upload copies of approved forms and correspondence.
5. **Communicate with Referral Provider**
    - Send referral information and relevant clinical records to the receiving provider.
    - Inform patient about the referral status, any appointment details, and coverage/authorization confirmations.
6. **Track and Follow-Up**
    - Monitor status of referral and pre-authorization requests.
    - Ensure all actions are completed in a timely manner.
7. **Maintain Accurate Records**
    - Ensure all documentation is complete, accurate, and securely stored in accordance with organizational policies and privacy regulations (e.g., HIPAA).

## 6. Documentation Requirements

| Step | Required Documentation |
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| Identifying Need | Clinical notes indicating reasons for referral |
| Insurance Verification | Insurance eligibility printout or screenshot |
| Pre-Authorization Request | Submitted forms, supporting records, payer correspondence |
| Referral Transmission | Referral cover letter, clinical summary sent to provider |
| Record Maintenance | Copies of all above, logged in EHR |

## 7. References

- Insurance payer manuals and referral policies
- Internal EHR documentation guidelines
- Organizational privacy and recordkeeping policies

## 8. Revision & Approval

**Date:** _____
**Prepared by:** _____
**Approved by:** _____