

## Hawaii State Health Planning and Development Agency

1177 Alakea St. #402 Honolulu, Hawaii 96813

Phone: 808-587-0788 Fax: 808-587-0783 Web: <https://health.hawaii.gov/shpda>**Healthcare Prior Authorization Report****Reporting Period: January 1 to December 31, 2025****(Due Date: January 31, 2026)****Instructions**

If your health plan covers the service(s) highlighted in **YELLOW** below (03, 04, 07, 08, 09, 13, 15),  
please complete the form(s) relevant to the service(s):

Services	Form #
01=At Risk Services	Form-1
02=Autism Services	Form-2
<b>03=Diagnostic Testing</b>	<b>Form-3</b>
<b>04=Durable Medical Supplies/Medical Equipment</b>	<b>Form-4</b>
05=Home and Community-Based Services	Form-5
06=Home Health Services	Form-6
<b>07=Inpatient Hospital Services</b>	<b>Form-7</b>
<b>08=Outpatient Hospital Services</b>	<b>Form-8</b>
<b>09=Physician Services</b>	<b>Form-9</b>
10=Preventive Services	Form-10
11=Rehabilitation Services	Form-11
12=Transportation Services	Form-12
<b>13=Behavioral Health</b>	<b>Form-13</b>
14=Other Services	Form-14
<b>15=Drugs</b>	<b>Form-15</b>

Additional copies of instructions and report forms are available at:

<https://health.hawaii.gov/shpda/agency-resources-and-publications/prior-authorization-reporting/>

Three (3) ways to return the report form(s) to SHPDA:	Questions?
1) Email to: <a href="mailto:dailin.ye@doh.hawaii.gov">dailin.ye@doh.hawaii.gov</a> , or	Email: <a href="mailto:dailin.ye@doh.hawaii.gov">dailin.ye@doh.hawaii.gov</a>
2) Fax to: 808-587-0783, or	Phone: 808-587-0852
3) Mail to: SHPDA Prior Authorization Report Hawaii State Health Planning and Development Agency 1177 Alakea St. #402, Honolulu, HI 96813	

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## Form-#: Sample

### Reporting Period: January 1 to December 31, 2025 (Due Date: January 31, 2026)

Name of Health Plan: ABC Health Plan	Report date: 1/6/2026
Name of Insurer: XYZ Health Insurance Company	
Address of Insurer: 1234 Street Name, City, Zip Code	
Name of Administrator: Name	Phone: (808)-123-4567
Completed by: (name) Name	Fax: (808)-100-2000
(title) Title	Email:

<b>Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests</b>							
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons?  Count one primary reason for each denial and enter the count for each reason in column F.  (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests	50000	40000	10000	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* <b>Specify. Add row as needed.</b>	
						01=Incomplete or Incorrect Information*	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)	35000	29500	5500	0	02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* <b>Specify. Add row as needed.</b>	
						01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)	10000	7500	2500	0	03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* <b>Specify. Add row as needed.</b>	
						01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
4.	Standard PA Decision Made after Appeal	5000	3000	2000	0	04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* <b>Specify. Add row as needed.</b>	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests							
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests	50000	40000	10000	0	01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	Enter Actual Counts
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)	35000	29500	5500	0	01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	Enter Actual Counts
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)	10000	7500	2500	0	01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	Enter Actual Counts
8.	Expedited PA Decision Made after Appeal	5000	3000	2000	0	01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	Enter Actual Counts

  

Section III. Time Between Receiving a Prior Authorization Request and Sending a Decision							
				Mean (Average) Time	Median (Middle) Time		
9.	Standard PA Decision Made within 7 Calendar Days			5	4	Day(s)	
10.	Standard PA Decision Made with Extension (up to 14 Days)			Optional	Optional	Day(s)	
11.	Standard PA Decision Made after Appeal			Optional	Optional	Day(s)	
12.	Expedited PA Decision Made within 72 Hours			1	1	Day(s)	
13.	Expedited PA Decision Made with Extension (up to 14 Days)			Optional	Optional	Day(s)	
14.	Expedited PA Decision Made after Appeal			Optional	Optional	Day(s)	

**Notes:****Column E: 01=Incomplete or Incorrect Information\***

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

**Column E: 04=Prior authorization timelines not met\***

This might also include expired authorization or duplicate requests.

**Column E: 07=Therapy requires multiple PA requests\***

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

**Column E: 09=Other\***

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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## Form-3: Diagnostic Testing

**Reporting Period: January 1 to December 31, 2025**  
**(Due Date: January 31, 2026)**

Name of Health Plan:	Report date:
Name of Insurer:	
Address of Insurer:	
Name of Administrator:	Phone:
Completed by: (name)	Fax:
(title)	Email:

<b>Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests</b>						
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Counts of Reasons (F)
1.	Standard PA Requests					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>

Section II. Expedited (Urgent) Prior Authorization (PA) Requests							
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5. Expedited PA Requests						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
6. Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
7. Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
8. Expedited PA Decision Made after Appeal						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	

  

Section III. Time Between Receiving a Prior Authorization Request and Sending a Decision			
		Mean (Average) Time	Median (Middle) Time
9.	Standard PA Decision Made within 7 Calendar Days		Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional
11.	Standard PA Decision Made after Appeal	Optional	Optional
12.	Expedited PA Decision Made within 72 Hours		Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional
14.	Expedited PA Decision Made after Appeal	Optional	Optional

**Notes:****Column E: 01=Incomplete or Incorrect Information\***

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

**Column E: 04=Prior authorization timelines not met\***

This might also include expired authorization or duplicate requests.

**Column E: 07=Therapy requires multiple PA requests\***

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

**Column E: 09=Other\***

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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## **Form-4: Durable Medical Supplies/Medical Equipment**

**Reporting Period: January 1 to December 31, 2025**

**(Due Date: January 31, 2026)**

Name of Health Plan:	Report date:
Name of Insurer:	
Address of Insurer:	
Name of Administrator:	Phone:
Completed by: (name)	Fax:
(title)	Email:

<b>Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests</b>						
	Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F.  (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests				01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)				01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)				01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
4.	Standard PA Decision Made after Appeal				01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests							
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	

  

Section III. Time Between Receiving a Prior Authorization Request and Sending a Decision							
				Mean (Average) Time	Median (Middle) Time		
9.	Standard PA Decision Made within 7 Calendar Days						Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)			Optional	Optional		Day(s)
11.	Standard PA Decision Made after Appeal			Optional	Optional		Day(s)
12.	Expedited PA Decision Made within 72 Hours						Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)			Optional	Optional		Day(s)
14.	Expedited PA Decision Made after Appeal			Optional	Optional		Day(s)

**Notes:****Column E: 01=Incomplete or Incorrect Information\***

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

**Column E: 04=Prior authorization timelines not met\***

This might also include expired authorization or duplicate requests.

**Column E: 07=Therapy requires multiple PA requests\***

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

**Column E: 09=Other\***

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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## Form-7: Inpatient Hospital Services

**Reporting Period: January 1 to December 31, 2025**

**(Due Date: January 31, 2026)**

Name of Health Plan:	Report date:
Name of Insurer:	
Address of Insurer:	
Name of Administrator:	Phone:
Completed by: (name)	Fax:
(title)	Email:

<b>Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests</b>						
	Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F.  (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests				01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)				01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)				01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
4.	Standard PA Decision Made after Appeal				01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests							
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	

  

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision							
				Mean (Average) Time	Median (Middle) Time		
9.	Standard PA Decision Made within 7 Calendar Days						Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)			Optional	Optional		Day(s)
11.	Standard PA Decision Made after Appeal			Optional	Optional		Day(s)
12.	Expedited PA Decision Made within 72 Hours						Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)			Optional	Optional		Day(s)
14.	Expedited PA Decision Made after Appeal			Optional	Optional		Day(s)

**Notes:****Column E: 01=Incomplete or Incorrect Information\***

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

**Column E: 04=Prior authorization timelines not met\***

This might also include expired authorization or duplicate requests.

**Column E: 07=Therapy requires multiple PA requests\***

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

**Column E: 09=Other\***

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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## Form-8: Outpatient Hospital Services

**Reporting Period: January 1 to December 31, 2025**

**(Due Date: January 31, 2026)**

Name of Health Plan:	Report date:
Name of Insurer:	
Address of Insurer:	
Name of Administrator:	Phone:
Completed by: (name)	Fax:
(title)	Email:

<b>Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests</b>						
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Counts of Reasons (F)
1.	Standard PA Requests					Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F.  (E) (*See note)
						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>

Section II. Expedited (Urgent) Prior Authorization (PA) Requests							
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	

  

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision							
				Mean (Average) Time	Median (Middle) Time		
9.	Standard PA Decision Made within 7 Calendar Days						Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)			Optional	Optional		Day(s)
11.	Standard PA Decision Made after Appeal			Optional	Optional		Day(s)
12.	Expedited PA Decision Made within 72 Hours						Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)			Optional	Optional		Day(s)
14.	Expedited PA Decision Made after Appeal			Optional	Optional		Day(s)

**Notes:****Column E: 01=Incomplete or Incorrect Information\***

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

**Column E: 04=Prior authorization timelines not met\***

This might also include expired authorization or duplicate requests.

**Column E: 07=Therapy requires multiple PA requests\***

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

**Column E: 09=Other\***

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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## Form-9: Physician Services

**Reporting Period: January 1 to December 31, 2025**  
**(Due Date: January 31, 2026)**

Name of Health Plan:	Report date:
Name of Insurer:	
Address of Insurer:	
Name of Administrator:	Phone:
Completed by: (name)	Fax:
(title)	Email:

<b>Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests</b>						
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Counts of Reasons (F)
1.	Standard PA Requests					Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F.  (E) (*See note)
						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>

Section II. Expedited (Urgent) Prior Authorization (PA) Requests							
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	

  

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision							
				Mean (Average) Time	Median (Middle) Time		
9.	Standard PA Decision Made within 7 Calendar Days						Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)			Optional	Optional		Day(s)
11.	Standard PA Decision Made after Appeal			Optional	Optional		Day(s)
12.	Expedited PA Decision Made within 72 Hours						Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)			Optional	Optional		Day(s)
14.	Expedited PA Decision Made after Appeal			Optional	Optional		Day(s)

**Notes:****Column E: 01=Incomplete or Incorrect Information\***

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

**Column E: 04=Prior authorization timelines not met\***

This might also include expired authorization or duplicate requests.

**Column E: 07=Therapy requires multiple PA requests\***

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

**Column E: 09=Other\***

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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## Form-13: Behavioral Health

**Reporting Period: January 1 to December 31, 2025**  
**(Due Date: January 31, 2026)**

Name of Health Plan:	Report date:
Name of Insurer:	
Address of Insurer:	
Name of Administrator:	Phone:
Completed by: (name)	Fax:
(title)	Email:

<b>Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests</b>						
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Counts of Reasons (F)
1.	Standard PA Requests					Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F.  (E) (*See note)
						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>

Section II. Expedited (Urgent) Prior Authorization (PA) Requests							
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5. Expedited PA Requests						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
6. Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
7. Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
8. Expedited PA Decision Made after Appeal						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	

  

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision			
		Mean (Average) Time	Median (Middle) Time
9.	Standard PA Decision Made within 7 Calendar Days		Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional
11.	Standard PA Decision Made after Appeal	Optional	Optional
12.	Expedited PA Decision Made within 72 Hours		Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional
14.	Expedited PA Decision Made after Appeal	Optional	Optional

**Notes:****Column E: 01=Incomplete or Incorrect Information\***

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

**Column E: 04=Prior authorization timelines not met\***

This might also include expired authorization or duplicate requests.

**Column E: 07=Therapy requires multiple PA requests\***

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

**Column E: 09=Other\***

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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## Form-15: Drugs

**Reporting Period: January 1 to December 31, 2025**  
**(Due Date: January 31, 2026)**

Name of Health Plan:	Report date:
Name of Insurer:	
Address of Insurer:	
Name of Administrator:	Phone:
Completed by: (name)	Fax:
(title)	Email:

<b>Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests</b>						
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Counts of Reasons (F)
1.	Standard PA Requests					Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F.  (E) (*See note)
						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>

Section II. Expedited (Urgent) Prior Authorization (PA) Requests							
		Total (A)	Approv- ed (B)	Denied (C)	With- drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5. Expedited PA Requests						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
6. Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
7. Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	
8. Expedited PA Decision Made after Appeal						01=Incomplete or Incorrect Information* 02=Medical necessity criteria not met 03=Non-covered services or exceeding limits 04=Prior authorization timelines not met* 05=Out-of-network providers 06=Lack of step therapy/testing attempts 07=Therapy requires multiple PA requests* 08=Non-formulary medications 09=Other* <b>Specify. Add row as needed.</b>	

  

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision			
		Mean (Average) Time	Median (Middle) Time
9.	Standard PA Decision Made within 7 Calendar Days		Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional
11.	Standard PA Decision Made after Appeal	Optional	Optional
12.	Expedited PA Decision Made within 72 Hours		Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional
14.	Expedited PA Decision Made after Appeal	Optional	Optional

**Notes:****Column E: 01=Incomplete or Incorrect Information\***

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

**Column E: 04=Prior authorization timelines not met\***

This might also include expired authorization or duplicate requests.

**Column E: 07=Therapy requires multiple PA requests\***

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

**Column E: 09=Other\***

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.