Pre-Approval Guidelines

General Requirements for Pre-Approval

Healthcare providers must obtain prior written authorization for all services requiring pre-approval, as stipulated in the member's policy. Providers are responsible for verifying pre-approval requirements and securing an authorization code via the Sukoon portal or other designated regulatory portals. Services rendered without prior authorization will not be reimbursed, and the provider will not have recourse for such claims.

Services Requiring Mandatory Pre-Approval Sukoon

- MRI, CT scan and PET Scan
- Endoscopic examinations (Including scopies requiring moderate sedation)
- Dialysis Sessions
- Physiotherapy
- Psychiatry Services
- Dental Services
- Optical Services: (if covered on direct billing as per eligibility verification)
    - Frames
    - Corrective lenses (including eyeglasses and contact lenses as per policy coverage).
- Individual Policy Holders with card Staring with **"IND"** require preapproval for services as per limit mentioned on the eligibility portal.
- In patient and Daycare procedures

In addition to above services, the below requires Pre-Approval for Bupa

- NT SCAN
- PAPP-A test
- Hearing Tests
- Services that need multiple treatment session including but not limited to Laser Therapy, Cryotherapy, Sclerotherapy, Arthrocentesis
- Optional Vaccines (to be sent through PBM)

Providers must refer to Eligibility Check details for any additional services subject to pre-approval requirements.

Approval for individual policies will be taken as per the amount mentioned on the portal at the time of eligibility verification.

Validity of Authorization Codes

Authorization codes are valid for thirty (30) days from the date of issuance or until the policy expiration date, whichever is sooner. Validity of approvals must be strictly adhered to, and the providers must ensure that the actual service start date is within 30 days following the ordered /activity start date on which approval is taken. Providers must confirm that authorization remains active and valid before delivering services.

Emergency Admissions

In cases of emergency, where pre-approval may not be feasible, providers must notify Sukoon in writing within twenty-four (24) hours of admission. Failure to provide timely notification may result in denial of claims. Providers are required to maintain medical documentation supporting the emergency nature of the service in the patient's records.

Documentation Requirements for Pre-Approval

All pre-approval requests must include the following documentation:
• Detailed medical records supporting the medical necessity of the service
• Diagnostic reports, where applicable
• Treatment plans, if required under the policy, initial cost estimate and LPO for high-cost consumables.

Incomplete or insufficient documentation will result in denial of pre-approval and claims will not be subject to further consideration or appeal.

Compliance with Pre-Approval Terms

Claims submitted for services requiring pre-approval must include an active and valid authorization code. Any claim submitted with an invalid, expired, or missing authorization code will be deemed invalid and will be denied without recourse to appeal or reconsideration.