



Oscar Health provider guide: Prior authorization submissions in Availity Essentials™

Important Dates: Effective Monday, June 15th, 2026, Availity Essentials users should view and submit authorization requests to Oscar Health. Here's what you should know:

Core Portal Expectations & Features

When using Availity Essentials for Oscar Health, keep the following core features and expectations in mind:

- **Initial Authorization Requests:** As of June 15th, all new initial authorization requests—including Notices of Admission, inpatient requests, and outpatient requests—should be processed directly through the Availity Essentials portal.
- **Automatic Delegated UM Redirection:** The authorization submission workflow is integrated with Oscar's clinical partners. Based on the specific service code requested, the portal will automatically redirect users to appropriate third-party
- Authorization vendors, such as eviCore or American Specialty Health (ASH).
- **The Authorizations Dashboard:** All authorizations submitted via Availity Essentials populate on the 'Authorizations Dashboard' page. Note that statuses on this page do not refresh dynamically; users must click on a specific authorization to trigger an automatic status update.
- **The Authorization Inquiry Page:** To check the status of any authorization not submitted via Availity Essentials (regardless of its original submission channel or date), use the 'Authorization Inquiry' page. For streamlined tracking, you can "pin" specific authorizations directly to your dashboard.
- **Oscar Payer Spaces:** Within the "Payer Spaces" section of Availity, you can access an array of Oscar-specific administrative resources. These include:
 - A quick link to the Oscar Provider Portal (to continue checking Member Eligibility & Benefits, viewing claims, etc.).
 - Prior Authorization Lists.
 - Out of Network Authorization Request Forms.
 - Clinical Medical Guidelines and Clinical Forms.
 - Oscar's Provider Manual and Monthly Newsletter.
- **Onboarding Support:** Providers can refer to the "Get started with Oscar" guide built directly within Availity Essentials for additional navigation support.



GENERAL PRIOR AUTHORIZATION SUBMISSION GUIDELINES	
TOPIC	INSTRUCTIONS
Submitting a Transplant Related Authorization	For all transplants AND any service related to a patient's transplant care, including evaluations, LVADs, pre- or post- transplant admissions, select service type Transplants in Availity's portal. When uploading / sending Oscar supporting clinical, ensure to document type of service (evaluation, DME, admission reason) and organ(s).
Submitting an authorization for Admission to Inpatient Level of Care from the ER (Concurrent Review)	Use service type: Emergency Services From Date – Enter the exact date the member was admitted to the Inpatient level of care (do not use the observation start date). To Date – Leave this blank unless the member has already been discharged. Only enter a date if it is a confirmed discharge. Note: Oscar will determine the number of approved days based on the service type and clinical criteria. Reminder: Labor and Delivery is covered under the global period. Authorization is not required for the first 2 days for vaginal birth or 4 days for cesarean. Do not use Emergency Services to submit a prior authorization for a planned admission, see table Service Type Uses for instructions on Elective Admission types.
Submitting an authorization for a Planned / Elective Inpatient Surgery or Procedure (Pre-Authorization)	Use service type: Medical Care for most planned admission OR Chemotherapy when applicable.



GENERAL PRIOR AUTHORIZATION SUBMISSION GUIDELINES	
	From Date – Enter the planned admission date to the selected facility/level of care. No “To” date is needed – Oscar will set the maximum admission valid window upon approvals. Oscar will determine the number of approved days based on the service type and clinical criteria.
Submitting an Authorization for a Post-Acute Admission (SNF, LTACH, Acute Rehab, Hospice)	Use the applicable service type: 45 – Hospice 54 – Long Term Care - A9 – Rehabilitation - AG – Skilled Nursing From Date – Enter the scheduled/planned admission date or the earliest date requested upon approval. Note: Oscar will determine the number of approved days based on the service type and clinical criteria.
Submitting an Out of Network (OON) Admission to Inpatient Level of Care from the ER (Concurrent Review)	Oscar accepts Out of Network Emergency Admissions requests via the Availity portal. Follow the instructions above re: Submitting an Admission to Inpatient Level of Care from the ER (Concurrent Review)
Submitting an Out of Network (OON) Pre-Service Authorization Request	Oscar now accepts Out of Network Pre-Service requests via the Availity portal. This includes elective/scheduled services. How to submit an out-of-network request in Availity



GENERAL PRIOR AUTHORIZATION SUBMISSION GUIDELINES	
	1. Submit the initial authorization: Log into Availity and submit your prior authorization request. 2. Locate the submission form: Go to Payer Spaces → Oscar Health → Resources to find the “Out of Network – Network Gap Exception Form – Online Submission.” 3. Complete and submit the form: Fill out the “Out of Network – Network Gap Exception Form – Online Submission” and attach it directly to your authorization request through the Availity dashboard. <i>Note: If you submit your authorization through Availity, you only need to complete the “Out of Network – Network Gap Exception Form – Online Submission.”</i> Alternative option: Submitting by fax If you are unable to submit an authorization in Availity, download the “<i>Out of Network – Network Gap Exception Form – Fax Submission</i>” packet from https://www.hioscar.com/forms/2026. Fill out the “<i>Out of Network – Network Gap Exception Form – Online Submission</i>” and “<i>Network Gap Exception Form</i>” and fax both forms along with your clinical documentation to 844-965-9053.
Service Timing of Authorizations (Pre-Service, Concurrent, Post-Service)	For Inpatient requests, we have built-in logic to help us understand when a request is pre-service, concurrent, or post-service. Here’s what to know: • For Inpatient Emergency requests (generally via ER/ED), be sure to select “Emergency Services” Service type and “Emergency” Admission type. ○ The “From” date should be used as the date the member/patient admitted to Inpatient level of care (not observation). ○ No need to populate the “To” date in this scenario unless there is a confirmed discharge date. • For Planned / Elective requests, if the service has already occurred, the portal does not support post-service. Please submit your claim.



GENERAL PRIOR AUTHORIZATION SUBMISSION GUIDELINES	
Submitting Additional Clinical Documentation	All outpatient requests will require clinical documentation as attachments. IP requests do not require clinical documentation, but it is recommended to submit available clinical information at time of authorization submission. If clinical is not available at time of submission (e.g. member admitted to the hospital <24-48hrs ago) please submit once clinicals become available): Additional clinical documentation can be submitted in Availity through both the Authorization Dashboard and the Authorization/Referral Inquiry. Dashboard: 1. Click on the request in the dashboard 2. Click 'Add Attachments' 3. Click '+ Add File' 4. Upload the document 5. Click 'Submit' 6. Upon successful submission, you will see a banner message that says 'Attachment Added Successfully' Inquiry: 1. Complete are relevant fields to locate the member via Inquiry 2. After completing all required fields, click 'Submit' 3. All requests associated with the selected member will reflect 4. Click on Certification Number of the authorization that requires additional clinical documentation 5. Click 'Add Attachments' 6. Click '+ Add File' 7. Click 'Submit' 8. Upon successful submission, you will see a banner message that says 'Attachment Added Successfully'



GENERAL PRIOR AUTHORIZATION SUBMISSION GUIDELINES

Request for **extension** of previously approved care

Extension Requests can be submitted via the Oscar Provider Portal or fax.

INPATIENT ADMISSION TYPE DESCRIPTIONS

Admission type indicates the priority and urgency of the patient's admission to the facility for an inpatient stay, indicating how and why the patient was admitted to a hospital bed.

ADMISSION TYPE	DEFINITION
Elective	An admission type utilized when a patient's medical condition permits the scheduling of a stay in advance. • Clinical Timeline: Scheduled (days, weeks, or months in advance). Delayed care will not cause immediate harm or clinical jeopardy. • Typical Source: Planned surgical procedures, scheduled labor inductions, or scheduled diagnostic workups.
Emergency	An admission type utilized when a patient requires immediate medical intervention to stabilize a condition that poses an imminent threat to life, limb, or long-term health. • Clinical Timeline: Immediate (minutes to hours). The patient cannot be safely stabilized without hospital admission. • Typical Source: Emergency Department (ED) or trauma transfers.
Newborn	A dedicated admission type used exclusively for the initial, immediate post-birth stay of an infant born within the facility. • Clinical Timeline: Immediate upon birth (spans the duration of the initial birth episode of care). • Typical Source: Labor and Delivery (L&D) suites, birthing centers, or immediate neonatal transfers.



LEVEL OF SERVICE DESCRIPTIONS

Level of service specifies the acuity required for the care being requested, setting the urgency of the medical necessity review. Emergency and urgent levels of service require attestation that an expedited turnaround time is required.

LEVEL OF SERVICE	DEFINITION
Elective	Utilized for routine, pre-planned treatments, procedures, or admissions. Delaying the service will not compromise the patient's health or safety.
Emergency	Utilized when an immediate, life- or limb-threatening crisis requires instant medical stabilization or hospitalization.
Urgent	Utilized when a patient has an acute condition requiring prompt medical attention that cannot wait for a standard elective window, but is not an immediate life-and-death crisis.

SERVICE TYPE DESCRIPTIONS

SERVICE TYPE	LEVEL OF CARE	DEFINITION
1 – Medical Care	Inpatient or Outpatient	General, non-surgical evaluation and management (E&M), diagnostic, and therapeutic services provided by a physician or qualified healthcare professional. Inpatient: Applies to daily acute care visits, subsequent hospital care, and consultations while the member is formally admitted to hospital or acute facility Outpatient: Applies to routine office visits, preventive exams, and clinic consultations where the member is not admitted
5 – Diagnostic Lab	Outpatient	Laboratory tests performed on clinical specimens (such as blood or urine) to obtain information about a patient's health for diagnosis, treatment, or prevention



SERVICE TYPE DESCRIPTIONS		
6 – Radiation Therapy	Outpatient	The use of high-energy radiation (such as X-rays) to shrink tumors and kill cancer cells, typically delivered in an outpatient oncology center.
11 – DME Used 12 – DME Purchased 18 – DME Rental	Outpatient	Used: Durable Medical Equipment that has been previously used or refurbished and is provided to the patient for therapeutic benefits. Purchased: The outright purchase of standard Durable Medical Equipment (e.g., blood sugar monitors, canes) for exclusive use by the patient. Rental: The temporary rental of Durable Medical Equipment (e.g., hospital beds, oxygen concentrators) based on short-term medical necessity.
33 – Chiropractice	Outpatient	Services provided by a licensed chiropractor focusing on the diagnosis, treatment, and prevention of neuromuscular disorders, with a primary emphasis on manual manipulation of the spine.
42 – Home Health Care	Outpatient	A wide range of healthcare services—ranging from skilled nursing to physical therapy—provided in a patient’s home for an illness or injury.
45 – Hospice	Inpatient or Outpatient	Compassionate, end-of-life care focusing on pain management and emotional support for terminally ill patients, typically delivered at home or in an outpatient hospice center.
54 – Long Term Care	Inpatient	Medical and non-medical care provided to patients who have a chronic illness or disability and require extended stays in a dedicated long-term care facility.
62 – MRI Scan	Outpatient	Magnetic Resonance Imaging; a non-invasive diagnostic imaging technology that produces detailed three-dimensional anatomical images without using ionizing radiation.
64 – Acupuncture	Outpatient	A complementary medicine practice involving the insertion of thin needles through the skin at strategic points to alleviate pain or treat various health conditions.
65 – Newborn Care	Outpatient	Routine, non-intensive evaluation and medical care provided to a healthy infant immediately following birth and through the first few weeks of life in an outpatient setting.

SERVICE TYPE DESCRIPTIONS		
66 – Pathology	Outpatient	The branch of medicine that checks tissue, blood, and fluid samples to diagnose diseases, typically performed by a laboratory pathologist.
69 – Maternity	Inpatient or Outpatient	Comprehensive care related to pregnancy, including antepartum (prenatal) care, labor and delivery, and postpartum care. Inpatient: Covers active labor, delivery, and the associated post-delivery hospital stay. Outpatient: Covers routine prenatal visits, ultrasounds, and outpatient postpartum checkups.
70 – Transplants	Inpatient or Outpatient	Services related to the evaluation, procurement, surgical implantation, and post-operative care for organ or tissue transplants (e.g., bone marrow, kidney, heart). Inpatient: Covers the acute surgical admission, donor harvesting, and immediate post-op recovery. Outpatient: Covers pre-transplant evaluations, workups, and long-term post-transplant follow-up care.
71 – Audiology	Outpatient	The evaluation, diagnosis, and non-medical treatment of hearing and balance disorders.
73 – Diagnostic Medical	Outpatient	General diagnostic tests and procedures (excluding standard lab/imaging) used to evaluate and identify specific medical conditions.
75 – DME Prosthetics	Outpatient	The provision and fitting of artificial devices (prosthetics) designed to replace a missing body part.
76 – Dialysis	Outpatient	Medical treatments used to filter waste and extra fluid from the blood when the kidneys can no longer perform this function adequately.
78 – Chemotherapy	Inpatient or Outpatient	The administration of chemical substances to treat cancer.

SERVICE TYPE DESCRIPTIONS		
		Inpatient: Required when a patient must be admitted for high-toxicity or continuous-infusion regimens. Outpatient: Applies to standard, routine infusions administered at an outpatient oncology center.
86 – Emergency Services	Inpatient	Specialized medical care and immediate stabilization services provided to a patient whose acute symptoms are severe enough to require an immediate, unscheduled admission to an inpatient hospital bed.
A9 – Rehabilitation	Inpatient or Outpatient	Multidisciplinary therapy (PT, OT, ST) to restore functional ability following injury or illness. Inpatient: Intensive therapy provided within an Inpatient Rehabilitation Facility (IRF) or unit. Outpatient: Therapy sessions scheduled at a freestanding clinic or outpatient hospital department.
AD – Occupational Therapy	Outpatient	Therapeutic treatments designed to help patients develop, recover, improve, and maintain the skills needed for daily living and working.
AF – Speech Therapy	Outpatient	The assessment and treatment of speech, language, communication, and swallowing disorders.
AG – Skilled Nursing Care	Inpatient	High-level medical care provided by licensed nurses in an inpatient skilled nursing facility (SNF), typically for rehabilitation or transitional recovery.
AR – Experimental Drug Therapy	Outpatient	The administration of investigational medications or treatments currently undergoing clinical trials that are not yet widely approved by the FDA.



SERVICE TYPE DESCRIPTIONS		
NI – Neonatal Intensive Care	Inpatient	Specialized, high-intensity inpatient care for critically ill, premature, or low-birthweight newborns in a NICU.
PT – Physical Therapy	Outpatient	Specialized treatment to restore movement, improve mobility, relieve pain, and prevent or limit permanent physical disabilities.

ERROR MESSAGE DESCRIPTIONS	
ERROR MESSAGE	EXPLANATION
Enter a valid date. The date cannot be prior to the coverage start date or more than 18 months in the future.	Home healthcare authorization requests cannot span across multiple plan years. If the request spans plan years, please submit multiple requests: one for services required until the end of the members current plan, and one for continued services under the new plan if the member is re-enrolled with Oscar.
Service Information :Input Errors (Post Service cannot be urgent.) – Please Correct and Resubmit. Transaction ID: #####	Post-service authorization requests cannot be urgent. Emergency Admission should only be used for Concurrent Review.
"Auth Required – Submit through EVICORE directly"	The requested CPT code belongs to a specialty category (like Advanced Imaging or Musculoskeletal care) managed by Oscar's partner, eviCore. NEXT STEPS: 1. Log into evicore.com
Auth Required – Submit through ASH directly	The requested service (such as Chiropractic, Acupuncture, or Routine Physical Therapy/Rehab) is managed by Oscar's clinical partner, American Specialty Health (ASH). NEXT STEPS: 1. Log into the ASHLink Provider Portal at www.ASHLink.com to submit the



ERROR MESSAGE DESCRIPTIONS	
	clinical authorization request. a. If you have not done so, call ASH to activate your ASHLink account at 1-800-972-4226; select option 2
All mental or behavioral health authorization requests must be submitted directly to Optum. Please contact Optum at (877) 855-1317.	All behavioral health, mental health, and substance use disorder services are managed externally by Oscar's partner, Optum Behavioral Health.
Invalid/Missing Subscriber/Insured ID – Please Correct and Resubmit. Transaction ID: 76879501105	The system cannot find a match for the Member ID entered. This is usually caused by a typo, a missing 3-letter prefix, use of hyphens, or the person not being an active Oscar member. NEXT STEPS: 1. Verify the ID number against the physical member ID card 2. Ensure you have included the 3-letter alphanumeric prefix OSC and any required suffixes (e.g. Person ID 01) Note: Don't enter a dash when populating the "Subscriber Member ID" field. Use the following format: Oscar Member ID OSC12345678-01 would be entered as OSC1234567801
Enter a valid date. The date cannot be prior to today or after 18 months from now for Admission Types Urgent and Elective.	Update the auth start ("to") date to start closer to submission date.



WITHDRAWAL REASONS	
WITHDRAWN MESSAGE	INSTRUCTIONS
Oscar is correcting a misclassified request.	Oscar will rebuild the request to ensure it is properly classified. No provider action is required unless contacted for additional clinical documentation. Check the Authorization inquiry page to locate your new auth ID. If you do not see a new request, please contact Oscar.
Oscar is correcting a misclassified request: Service Type, Place of Service, and/or Level of Care.	Oscar will rebuild the request to ensure the request reflects the proper Service Type, Place of Service, and/or Level of Care. No provider action is required unless contacted for additional clinical documentation. Check the Authorization inquiry page to locate your new auth ID. If you do not see a new request, please contact Oscar.
Oscar is correcting a misclassified request: Network Status.	The request is not In Network and must follow Oscar's Out of Network process. See instructions under GENERAL PRIOR AUTHORIZATION SUBMISSION GUIDELINES for "Submitting an Out of Network (OON) Pre-Service Authorization Request."
Oscar is correcting a misclassified request: Transplant	This request will be rebuilt under the proper transplant workflow. No provider action is required unless contacted for additional clinical documentation. Ensure to use the service type TRANSPLANT if/when submitting additional requests related to this member's transplant care.
Request withdrawn by provider.	This request was canceled per your facility's/office's explicit instruction. If this was done in error, please submit a new authorization request through the portal.
Duplicate: The original authorization is processing.	No action required. An identical request is already actively being reviewed by Oscar. Please reference the status of the first (original) authorization submission.



WITHDRAWAL REASONS	
Duplicate: The original authorization has been denied.	The original request was already reviewed and denied. Do not resubmit. Please reference the original request ID to review the denial rationale or to initiate the formal appeal process.
Duplicate: The original authorization has already been approved.	No further action needed. An active approval is already on file for these services. Please reference the original approved request ID for your approval determination.
The member is no longer effectuated.	Coverage is inactive. Verify the member's current eligibility status, enrollment dates, and policy ID before rendering services or resubmitting.
Authorization is not required.	The submitted codes do not require prior authorization under the member's specific plan.
The authorization request was submitted for the incorrect member.	The patient information provided does not match the clinical documentation. Please verify the patient's Oscar ID and date of birth, then submit a new request for the correct member.
Submit to Progeny for review.	This request falls under specialized routine/NICU management delegated to Progeny Health. Please resubmit this authorization request directly via the Progeny Health portal.
Submit to eviCore for review.	These services (e.g., radiology, MSK, oncology) are delegated to eviCore. Please log into the eviCore provider portal to submit this request and upload clinical documentation.
Submit to Ash for review.	This request is for occupational or physical therapy delegated to American Specialty Health (ASH). Please submit the request directly through the ASH Link portal.
Submit to Optum for review.	This request covers behavioral health or specialized therapies managed by Optum. Please submit your authorization request directly through the Optum Provider Express portal.



WITHDRAWAL REASONS	
Oscar is addressing an issue with this request.	Oscar's internal team has intercepted this request to resolve a system or administrative error. The team will reach out directly if further clinical details or updates are required.
The member has expired.	This authorization cannot be processed. The member has passed away prior to receiving services.
Request withdrawn by member.	The patient (or their designated representative) has requested that this authorization request be canceled. Please discuss next steps directly with the patient.
The claim has already been paid.	This request was submitted retroactively for services that have already been adjudicated and paid. No further authorization action is required.
This case should be an extension.	Locate the original, existing approved authorization in the portal and submit an extension request to add more units, visits, or days.
Invalid Requestor (Unauthorized Representative).	The requesting provider or entity does not have an established relationship or authorized consent on file to request services for this member. Please submit valid representation paperwork or contact Oscar.

FREQUENTLY ASKED QUESTIONS (FAQ)

1. How can I submit clinicals if I am unable to submit them via Availity's portal?

Fax clinical records to Oscar at (844) 965-9053. Alternatively, give us a call at 855-OSCAR-55 and follow the prompts for an existing case to reach our utilization review team.

We value your feedback. Tell us about your experience with the new Availity portal and where there are additional questions. Visit oscar.surveymonkey.com/r/AvailityFeedback or scan the QR code below to take our brief survey.

