

Understanding your insurance approval — and what “part approved” means

Before big procedures, insurers give approvals in writing. Here is how to read one — and what to do when it says “part approved.”

Choosing treatment

Educational draft. Clinical review pending. Quotations retained from the original text are not verified member testimonials.

Insurance approval (sometimes called pre-authorization or pre-certification) is the step where your insurer reviews the planned procedure and agrees to pay for it. “Part approved” means exactly what it sounds like: some parts of the plan were approved and others were not — or were approved at a different level than requested.

This is one of the most confusing letters anyone receives, and it usually arrives with no explanation. The important thing to know: “part approved” is not a final “no.” It is often a paperwork problem — a code mismatch, a missing document, a question about medical necessity — and appeals succeed more often than people expect.

Three groups are in the room with you: the insurer, the hospital’s billing and case-management team, and your doctor’s office. The letter comes from the first, but the second and third have the tools to answer it — they know the codes, the forms, and the people. Your job is simply to connect the three.

What to do when you get the letter

1. Read it twice and underline the words “approved” and “not approved” — know exactly which is which.
2. Ask for it in writing. Verbal answers drift; the letter is what counts.
3. Ask which specific parts are approved: the surgery itself, the hospital stay, the anesthesia, the follow-up visits.

4. Ask who appeals. Usually your doctor's office or the hospital's billing team files the appeal — and they do it all the time.
5. Ask about deadlines. Appeals often have a window, and missing it is the only truly avoidable loss.

What to ask your team

- Who handles insurance approvals at this hospital or clinic — and can I speak to that person directly?
- Can you itemize, line by line, what was approved and what was not?
- What is the appeal process, and how long does it take?
- If part is not approved, what does that mean for my care — and for my bill?

When the answer is a clear no

If the letter is a straight refusal rather than a partial approval, the same steps apply, with one addition: ask for the written reason and the specific policy clause the insurer relies on. A good appeal answers that exact reason, line by line. And if the first appeal is refused, ask whether a second level exists — many plans have more than one.

Take it to your team

Take the letter itself, not your memory of it. Hand it over and ask: "Translate this for me in plain words. What is approved, what is not, what can be appealed, and who does it?" Write down the answer and the deadline.

Insurance paperwork is exhausting, but it is not a medical decision — and it should never be the thing that quietly decides your care. Your team's job is to fight for the plan they believe in; yours is to stay informed. The final decision on your treatment belongs to you and your own medical team.

Questions to take to my team

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For discussion and personal reference. Your care team's individual instructions take priority. For an emergency, contact your local emergency service; do not wait for a community reply.