HMO Referral Process

What is a referral?

Your Aspirus Health Plan insurance coverage is a Health Maintenance Organization, or HMO, plan. That means, other than emergency room visits, most services are only covered when you see a participating provider. If you choose a nonparticipating provider, except for emergency room care, those services are not covered.

In certain limited situations, your provider may refer you to a nonparticipating provider. But services from that nonparticipating provider only will be covered if you receive an **approved referral**.

When do I need to obtain a referral?

Anytime you or your participating provider want care from a nonparticipating provider, not including emergency room services, you need a referral.

For example, you may need an approved referral for a nonparticipating provider when:

- The specialty or service is not available from a participating provider.
- The specialist or service is available from a participating provider, but may require you to travel an unreasonable distance to see that provider, particularly for ongoing care.

Keep in mind that nonparticipating provider services are only covered when you:

- Visit an emergency room
- Have an approved referral

If we do not approve a written referral request, you may still obtain care from a nonparticipating provider, but those services **will not be covered**.

How do I get an approved referral?

To get your referral approved, your provider must complete the referral section of Aspirus Health Plan's Prior Authorization Request Form. For a downloadable PDF, visit **aspirushealthplan.com/insurance/Prior Authorization** and select **Prior Authorization Request Form**.

Your doctor must submit the completed form, along with supporting clinical documentation, directly to Aspirus Health Plan's Integrated Health Services Department.

When we receive the request, Aspirus Health Plan's Integrated Health Services Team will review it and send our decision to you and your provider in writing.

How long is an approved referral valid?

Referrals are evaluated on a case-by-case basis. A referral request may be approved for up to a year. We will let you and your provider know, in writing, how long your referral remains valid when we make our determination.

What happens if my referral is not approved?

If your referral request is not approved, you may appeal. Your health plan certificate has details about the appeal process. You also can contact our Customer Service department at 866.631.5404 .

Who can I contact with questions?

If you have any questions about the referral process, including whether an in-network referral may be an option, the best place to start is our Customer Service department. We can be reached at **866.631.5404, Monday–Friday from 7 am - 5 pm**.

What happens if my referral is approved?

If your referral is approved, the maximum allowable fee levels will apply to nonparticipating providers and services. The amount the plan pays is the allowed amount for any covered service. But if a nonparticipating provider charges more than the allowed amount, you may have to pay the difference.

Here's an example. You go to a nonparticipating hospital, which charges $1,500 for an overnight stay. If the allowed amount is $1,000, you may have to pay the $500 difference. This is called balance billing.

If your provider has questions about the status of a referral request, he or she can call our Integrated Care Management Department at 866.631.5404.