POS Referral Process

What is a referral?

Your Aspirus Health Plan insurance coverage is a Point-of-Service (POS) plan. That means you are free to use any health care provider you choose. However, your benefits are better and you have lower out-of-pocket costs when you use in-network providers. When you use out-of-network providers, your out-of-pocket costs are higher.

In certain limited situations, services from an out-of-network provider can be paid at the in-network level, if you get an **approved referral**.

This may be the case when:

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

Keep in mind that out-of-network provider services are paid at the in-network level only when you visit an emergency room or have an **approved referral**. If the referral is not approved, you can still see an out-of-network provider, but understand that services will be paid at the out-of-network level of benefits, meaning higher costs for you.

When do I need to obtain a referral?

Anytime you would like to have out-of-network specialty services paid at the in-network benefit level, a referral is necessary.

Keep in mind that referral requests will not be approved if the services are available within the network and travel is determined to be reasonable for the services needed. You are able to see the out-of-network provider, but coverage will be at the level for out-of-network care.

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/ insurancebytopic**. Under **Forms and Authorization Lists** 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, we 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, Monday - Friday, 7 am - 5 pm**.

Remember, with a POS plan, you can choose to see an out-of-network provider without an approved referral, with the understanding that services will be paid at the out-of-network level of benefits.

Who can I contact with questions?

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

What happens if my referral is approved?

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

Here's an example. You go to an out-of-network 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.