Out-of-Network Referral Request Form

Please return the completed form and applicable supporting clinical documents to:
Aspirus Health Plan, Attn: Medical Management, PO Box 1890, Southampton, PA 18966 or
Fax: 763.847.4014
Determinations will be faxed or delivered via phone and a letter will be mailed to the patient with a copy to the Out-of-Network Provider. Notice: If the incorrect Out-of-Network Provider information is on this form, claims may be denied.

DATE OF REQUEST	
START TO END DATE RANGE FOR SERVICES	-

PATIENT INFORMATION

Patient Last Name	Patient First Name	Member ID	Patient Date of Birth

IN-NETWORK PROVIDER REQUESTING OUT-OF-NETWORK REFERRAL

Name of In-Network Provider Requesting Out-of-Network Referral			Provider NPI
Site/Location Name		**TIN**	**Billing NPI**
Site/Location Address	**City**	**State**	**ZIP**
Site/Location Contact Person	**Phone**	**Fax**	

OUT-OF-NETWORK PROVIDER INFORMATION

Reason for Referral: ☐ Unavailable In-Network ☐ Health Plan Requirement

Name of Out-of-Network Provider			Provider NPI
Site/Location Name		**TIN**	**Billing NPI**
Site/Location Address	**City**	**State**	**ZIP**
Site/Location Contact Person	**Phone**	**Fax**	
Name of Facility Where Patient will be Seen and/or Treated		**TIN**	
Site/Location Address	**City**	**State**	**Zip**

Summarize Requested Service(s) that are not Available In-Network

ATTACH APPLICABLE OFFICE NOTES AND DIAGNOSTIC TESTING RESULTS FOR THIS REQUEST

Workers Compensation ☐ Yes ☐ No Date of Injury/Loss _____

Motor Vehicle Accident/Subro ☐ Yes ☐ No Date of Injury/Loss _____

Other Coverage ☐ Yes ☐ No Insurance Company _____

NOTE: The prior authorization of any procedure does not guarantee benefits or payment. Approval is based on medical necessity as defined in the patient's benefit plan or certificate. All benefits are subject to the terms, conditions, and exclusions of the benefit plan or certificate. This may include policy language regarding pre-existing conditions or signed affidavits stating that the insurance bears no responsibility, as signed by the insured. Policy exclusions for certain types of services may also apply. Verify prior authorization requirements. For additional benefit information, please contact Aspirus Health Plan at 866.631.5404. **A release of information form included in the application for insurance was signed by our member.**

SERVICES REQUESTED *(Supporting clinical documentation and diagnostic test results must accompany this request)*

☐ Consult Only ☐ Follow-Up ☐ DME ☐ Lab/X-Ray ☐ Home Care ☐ Hospice ☐ Skilled Nursing

☐ Outpatient Therapy *(Physical, Occupational, Speech)*: ☐ Habiliatative ☐ Rehabiliatative

☐ Surgery: ☐ Inpatient ☐ Outpatient ☐ Other _____

Primary Diagnosis Code	Description
Procedure/HCPCS Code(s)	Description