Out-of-Network Referral Form

Referrals to out-of-network providers must be authorized before the service.

Call (616) 464-6619 or (800) 638-0573 • Fax (616) 464-4465
Mail claims to ASR Health Benefits, P.O. Box 6392, Grand Rapids, MI 49516-6392

I. PATIENT INFORMATION:
   a. Patient Name: __________________________
   b. Date of Birth: __________________________ c. Patient is: ☐ Member ☐ Spouse ☐ Dependent

II. MEMBER INFORMATION:
   a. Member Name: __________________________
   b. Member’s Employer: ______________________ c. Member ID Number: ______________________
   d. Member accepts financial responsibility for out-of-network referral? ☐ Yes ☐ No

III. OUT-OF-NETWORK PROVIDER:
   a. Provider Name: __________________________
   b. Address: ________________________________ c. Phone Number: __________________________
   d. Specialty: ________________________________ e. Appointment Date: ______________________
   f. Patient Diagnosis (narrative and ICD-9 code): __________________________
   g. Type of Service Requested (including CPT code):
      ☐ Consultation Only (lab, x-ray, and/or treatment not authorized)
      ☐ Consultation with Lab and/or X-ray
      ☐ Consultation and Treatment - CPT Codes: __________________________
      ☐ Emergency Room Visit - Date: __________________________
      ☐ Outpatient Surgery - CPT Codes: __________________________ Date: __________________________
      ☐ Inpatient Surgery - CPT Codes: __________________________ Date: __________________________
      ☐ Office Visits - Frequency and Duration: __________________________
      ☐ Other: __________________________

IV. REASON FOR OUT-OF-NETWORK REFERRAL REQUEST:
   ☐ No participating provider for requested service
   ☐ No participating provider within 60 miles/Out of area
   ☐ Continuity of care (patient has established relationship with provider)
     Length of relationship: __________________________ Approximate date of last patient visit: __________________________
     Explain importance: __________________________
   ☐ Other: __________________________ Pertinent Comments: __________________________

V. PRIMARY CARE PHYSICIAN:
   a. Name (type or print): __________________________ b. Date: __________________________
   c. Phone Number: __________________________ d. Fax Number: __________________________

FOR OFFICE USE ONLY:

VI. AUTHORIZATION NUMBER: __________________________

VII. CASE MANAGER: __________________________
   Date: __________________________