ASR health benefits

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: _____

Revised 8/23/13