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REFERRAL POLICY

Some insurance plans require referrals, or pre-authorizations for services provided at a specialist office, diagnostic center, hospital, etc. Our office does have a referral coordinator on staff to process the referrals, and pre-authorizations through the insurance for patients requiring one. However, it is the responsibility of the patient to notify the referral coordinator of any scheduled appointments they may have in order to obtain a referral, or pre-authorization. Including but not limited to appointment scheduled with a physician or facility recommended by a physician or employee at our office. A verbal recommendation is not a referral.

Due to the ever changing contracts between the insurance companies and medical service providers we do not guarantee that a provider we recommend is in network with your insurance.

A prior notice of at least 3 business days is requested, in order to ensure enough time is given for our referral coordinator to process each request, as well as for your insurance to review the request for referral or pre-authorization. Failure to provide adequate notice may result in the patient having to reschedule their appointment.

A request for referral, authorization, or pre-approval does not guarantee coverage. The insurance company may need to review the request to determine if it is medically necessary according to their guidelines. In the event that the clinical information provided does not meet their criteria for approval, the request will be denied. Should this occur you will be notified of the denial by our office, as long as we initiated that request. Completion of a referral does not guarantee payment by the insurance. The written terms of the contract will apply.

If an insurance plan requires a referral or pre-authorization for services rendered, and the service is provided without approval, coverage may be denied.

I have read and agree to the above stated policy.

Patient's Signature: _____

Patient's Printed Name: _____

Date: _____

Patient's Account: _____