Out-of-Network Referral Request Form

Please return the completed form and applicable supporting clinical documents to:

Aspirus Health Plan, Attn: Integrated Health Services, PO Box 1062, Minneapolis, MN 55440
or Fax: 763.847.4014

DATE OF REQUEST	
START DATE OF SERVICES	

PATIENT INFORMATION

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

ORDERING PROVIDER INFORMATION

Ordering Provider Name			NPI
Site/Location Name		**TIN**	**NPI**
Site/Location Address	**City**	**State**	**ZIP**
Site/Location Contact Person	**Phone**	**Fax**	

☐ Fax notifications related to this request *(by checking this box, you will not receive mail notifications).*

REFERRING PROVIDER INFORMATION

Reason for Referral: ☐ Patient's Request ☐ MD Preference ☐ Unavailable in Network ☐ Health Plan Requirement

Servicing Provider Name			NPI
Site/Location Name		**TIN**	**NPI**
Site/Location Address	**City**	**State**	**ZIP**
Site/Location Contact Person	**Phone**	**Fax**	

Comments *(indications for referral)*

SERVICES REQUESTED *(Supporting clinical documentation 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**

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.**