

# REFERRAL POLICY

## **Benefit Eligibility**

---

The Practice will ensure that managed care patients receive medical services consistent with their benefit plan. Front desk staff will be required to verify benefit eligibility at the time of appointment scheduling or prior to patient check-in.

1. We will inform you if you have run out of allowed visits or if the service required is not covered by your benefit plan.
2. If you are being seen for a non-covered services, you will be told at the time of scheduling that the service will be considered self-pay. You will be asked for payment in full at the time of service.
3. If you are unable to show proof of insurance or benefits for the services to be rendered, you will be requested to sign a waiver form.
4. A system-generated receipt will be given to you when you check-out that indicates the amount charged for the non-covered services and the amount you paid.

## **Referral Authorizations**

---

For the appropriate services, a Referral Authorization Number Form must be obtained from you or the referring physician (Dr. Arnevilla) before being treated by the referred-to physician. This policy holds true for referrals from the Practice as well as other community physicians.

If your insurance provider does not provide coverage for the

service (non-covered service), the referred-to physician office will likely charge you directly. If this is the case, expect that you will be asked for payment in full at the time of service.

## **Referral Timeliness**

---

Dr. Arnecilla will provide timely referrals to approved specialists and for approved services within your insurance network, when appropriate.

Dr. Arnecilla may indicate that the results of laboratory or imaging tests are needed before the referral is processed in order to best serve your medical needs. Dr. Arnecilla should discuss this with you at the time of your visit.

Please allow at least 72 hours for AFFM to process your referral(s). Your insurance provider must give us a referral authorization number. Without this number, the specialist we refer you to may not allow you to schedule an appointment. Each insurance company has its own referral policy, so response time will vary.

- a. We notify you of the referral authorization number and specialist information by your pre-authorized method of contact (email, telephone, mail).
2. Three copies of the referral exist: one (1) copy is given to you; one (1) copy is forwarded to the referred-to physician; and one (1) copy is available in your medical record.
3. This document is intended as a general policy. Each payer may have specific requirements for referrals.

## **Primary Care Physician Election**

---

All patients enrolled in a contracted HMO, POS or EPO Health Plan must select a Primary Care Physician or a specialist prior to the first visit and in accordance with the terms of the benefit contract.

1. The HMO or other contracted health plan must approve the Primary Care Physician selection.
2. The Primary Care Physician or specialist will be recorded during the registration process.
3. If the patient presents for care and has not elected one of the physicians, the patient will not be able to receive treatment without the HMO's written approval. This can be expedited by fax if the HMO has the capability.