Referrals and Prior Authorization
Guide for Members

A referral is a written order from your primary care physician or specialist for a specific medical service or test. Referrals are required to ensure that patients are seeing the correct providers for the correct problems. Prior authorization is a decision by your health plan that a service, treatment plan, prescription drug or medical equipment is medically necessary. Failure to obtain the necessary referral and/or prior authorization before having certain tests or medical services can result in coverage not being applied to a visit, test or service, resulting in costs being passed directly to the patient.

For Generations Medicare Advantage 2022 Plans:

✓ Members can self-refer for any in-network specialist office visit – no referral from your primary care physician or prior authorization from GlobalHealth is required for the office visit or routine office services.

- Services Provided in the Specialist's Office are Covered
- In-Office Procedures are Covered

✓ Certain tests and treatments require prior authorization, even when provided in the specialist's office.

Examples include but are not limited to:

- Physical, Occupational or Speech Therapy
- Cardiac or Pulmonary Rehabilitation
- Outpatient Surgery in an Outpatient Surgical Location or Outside the Specialist's Office

✓ Certain services and tests require prior authorizations, even when provided in the specialist's office, and may require one or multiple copays.

Examples include but are not limited to:

- Specialized Outpatient Diagnostic Tests (MRI, CT, Etc.)
- Part B Drugs

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Things to consider when you are referred for a service, treatment, prescription drug or medical equipment that needs to be preauthorized:

✓ Make sure your health care providers have your current insurance information. This is important because each plan has its own unique set of conditions for referrals.

✓ The preauthorization process may take up to 14 days. In some cases, your provider may want to schedule the appointment sooner and ask for an expedited review, these are completed within 72 hours. Review your member benefit package for more information.

- This timeline is much quicker for prescription drug determinations, both Part B and Part D determinations are provided within 24 – 72 hours.

✓ Please keep in mind that specialists often have a process of their own that may impact the timeframe you are scheduled for the needed service. They may screen referrals for clinical appropriateness by reviewing your complete medical record, such as visit notes, lab and x-ray results. A signed medical record release may need to be obtained.

- It is not uncommon for a specialist to review the case and ask for further tests to be done prior to the office visit. These tests may require authorization.

✓ If your provider told you a referral would be made and it has been at least two weeks with no updates, please call the provider's office to check on the status of your referral.

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