Referrals and Prior *Authorizations*

A **referral** is a written order from your primary care physician (PCP) 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.**

Some services require referral, some services require prior authorization, and some services require both referral and prior authorization. See your Evidence of Coverage (EOC) for details.

For GlobalHealth Generations Medicare Advantage 2025 Plans:

- **You can refer yourself for any in-network specialist office visit.** You do not need a referral from your primary care physician (PCP) or prior authorization from GlobalHealth for an in-network specialist office visit or routine office service.
  - Services Provided in the Specialist's Office are Covered
  - In-Office Procedures are Covered
- **Certain services, tests and treatments do require prior authorization, whether or not they are provided in the specialist's office.** The specialist should submit an authorization request for you. 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
  - Genetic Testing
- **Certain services and tests require prior authorizations, as well as additional copays, even when provided in the specialist's office on most plans.**

  Examples include but are not limited to:
  - Specialized Outpatient Diagnostic Tests (MRI, CT, etc.)
  - Part B Drugs

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

- Make sure your health care provider(s) have your current insurance information. This is important because each plan has its own unique set of conditions for referrals.
- The prior authorization 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 time frame 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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