Northcrest Health Plan

Member Services · P.O. Box 55210, Riverbend, ST 58023
Member services 1-800-555-0210 (TTY 711), Mon–Fri 7:00a–7:00p Central
northcresthealthplan.example · Plan year 2028

MEMBER EXPLANATION

Document
Member explanation — referral and prior authorization
Plan
Northcrest Select HMO 2000
Version
4.1 · Effective 01/01/2028
Owner
Utilization Management · reviewed by Compliance 12/2027

A Referral and a Prior Authorization Are Two Different Things

Two separate processes, two sets of timelines, two kinds of notice — and neither one is a promise that a claim will be paid

AN APPROVAL IS A MEDICAL-NECESSITY DECISION, NOT A GUARANTEE OF PAYMENT

Payment also depends on your eligibility on the date of service, the benefits in the Evidence of Coverage (form NCH-EOC-2028), the network status of every provider involved, and correct claim submission. The Evidence of Coverage controls.

MEMBER	MEMBER ID	PLAN	PRIMARY CARE PROVIDER
Marisol T. Okafor	NCH-884215017	**Northcrest Select HMO 2000 — PCP required, referral required for specialists**	**Elena Sorrentino, MD — Riverbend Family Medicine**
PRIOR AUTHORIZATION LINE	PHARMACY HELP DESK	APPEALS UNIT	CONTROLLING DOCUMENT
1-800-555-0214, Mon–Fri 8:00a–6:00p Central	**1-800-555-0216, 24 hours**	**Fax 1-855-555-0219 · P.O. Box 55219, Riverbend, ST 58023**	NCH-EOC-2028 **sections 6 and 9**

THE TWO LANES, SIDE BY SIDE

	LANE A — REFERRAL	LANE B — PRIOR AUTHORIZATION
What it is	Your PCP's record with the plan that you are being sent to a named specialist	The plan's advance review of whether a specific service meets the medical-necessity criteria in the Evidence of Coverage
Who starts it	Your PCP's office, in the provider portal	The ordering provider — your PCP, the specialist, the facility, or your prescriber
Can you start it yourself?	No. Ask your PCP's office to submit it; you can confirm it was submitted.	No. You can call 1-800-555-0214 to check the status of a request at any time.
What is submitted	Specialist name and location, specialty, reason, number of visits requested	Clinical notes, the diagnosis and procedure codes, prior treatment tried, imaging or test results, and the requested date and place of service
How long it takes	Recorded within 2 business days of submission	Standard medical: within 14 calendar days of a complete request. Expedited: within 72 hours. Pharmacy: 72 hours standard, 24 hours expedited.
Can it be extended?	No	Yes — up to 14 additional calendar days if information is missing, with written notice explaining what is needed
How long it lasts	90 days from the date issued, covering up to 4 visits with the named specialist unless the referral says otherwise	90 days from the approval date for medical services, unless the notice states otherwise. Pharmacy exceptions run through 12/31/2028.
What it does	Satisfies this plan's requirement that specialist care be arranged through your PCP	Confirms the service met the medical-necessity criteria applied on the day of review
What it does not do	It does not confirm the specialist is in network on the date of service, does not substitute for a prior authorization, and does not guarantee payment.	**It does not guarantee payment.** Eligibility, benefits, network status, and correct claim submission all still apply.
If it is refused	Discuss it with your PCP. A referral that is returned for correction is not a denial and has no appeal rights.	You receive a written denial with the reason, the criteria used, how to get a free copy of those criteria, and your appeal rights.

SERVICES THAT REQUIRE PRIOR AUTHORIZATION ON THIS PLAN

SERVICE	THRESHOLD
Non-emergency inpatient admission	Always, before admission
Advanced imaging — MRI, CT, PET	Always, except in an emergency room
Outpatient surgery	When the allowed amount exceeds $2,500
Durable medical equipment	When the purchase price exceeds $1,500
Home health	From visit 11
Physical and occupational therapy	From visit 13
Specialty drugs in Tier 5	Always
Genetic and molecular testing	Always
Any out-of-network service	Always, and approved only in limited circumstances
Emergency care	**Never** — notify the plan within 2 business days of an admission

This list is a summary. Section 6 of NCH-EOC-2028 is the complete and controlling list, and it can change during the plan year with notice.

STATUS NAMES YOU WILL SEE IN THE PORTAL

`Received`	The request is logged. The clock starts on the date a complete request is received, not the date it was written.
`Pending review`	A nurse or physician reviewer has the file.
`Info requested`	Something is missing. The requesting provider has been told exactly what. The decision clock can extend up to 14 calendar days.
`Approved`	The criteria were met. An approval number and a validity window are issued.
`Partial`	Some of what was requested was approved — for example 8 visits of the 12 requested. The rest carries appeal rights.
`Denied`	The criteria were not met. The written notice states the reason and your appeal rights.
`Withdrawn`	The requesting provider cancelled the request.
`Expired`	The validity window ended before the service happened. A new request is needed.

A WORKED EXAMPLE — MEDICAL PRIOR AUTHORIZATION, START TO FINISH

DATE	TIME	EVENT	STATUS AFTER THIS EVENT	WHO ACTED	NOTICE SENT
01/22/2028	2:40p	Dr. Kwame Bristol orders an MRI of the lumbar spine and submits the request	Received	Specialist office	Portal entry only
01/23/2028	9:15a	Nurse reviewer opens the file	Pending review	Northcrest UM	None
01/26/2028	11:02a	Six weeks of conservative treatment records are not in the file; they are requested	Info requested	Northcrest UM	Letter to member and provider, 01/26
01/29/2028	4:50p	Physical therapy notes for 11/27/2027–01/12/2028 are received	Pending review	Specialist office	None
02/02/2028	10:26a	Physician reviewer approves the request	Approved — `PA-2028-0202-7731`	Northcrest UM	Approval letter to member and provider within 2 business days
02/02/2028	—	Validity window set: 02/02/2028 through 05/02/2028 (90 days)	Approved	Northcrest UM	Stated in the approval letter
02/19/2028	8:00a	MRI performed at Cedar Point Regional Medical Center, in network	Approved and used	Facility	None
03/06/2028	—	Claim processed: allowed $1,410, deductible applied $1,128, coinsurance 20% of $282 = $56.40, member responsibility $1,184.40	Claim finalized	Northcrest Claims	Explanation of benefits

The approval did not reduce what this member owed. It confirmed medical necessity; the deductible and coinsurance in the Evidence of Coverage still determined the amount. This is exactly why an approval is not a guarantee of payment.

A WORKED EXAMPLE — PHARMACY PRIOR AUTHORIZATION

DATE	EVENT	RESULT
02/01/2028	Prescription for Calvaxen 40 mg presented at the pharmacy	Rejected at the counter, reason code 75 — prior authorization required
02/01/2028	Pharmacy help desk called on 1-800-555-0216	Requirement explained; prescriber notified the same day
02/03/2028	Prescriber submits the request at 10:14a	Received
02/05/2028	Decision issued, within the 72-hour standard window	Approved — PA-2028-0205-4418
02/05/2028	Validity window set	Through 12/31/2028
02/06/2028	Prescription filled, 30-day supply, Tier 3	$75 copay, quantity limit 30 tablets per 30 days applied

Tier and quantity limit come from the 2028 drug list, NCH-FORM-2028.

IF A REQUEST IS DENIED

STEP	DEADLINE	DECISION WITHIN
Ask for a free copy of the criteria used	Any time	5 business days
Peer-to-peer call between your provider and the reviewer	Before filing an appeal	Scheduled within 3 business days
Internal appeal	Within 180 calendar days of the denial notice	30 calendar days before service, 60 calendar days after service
Expedited internal appeal, when waiting would seriously jeopardize health	Any time	72 hours
External review by an independent organization	Within 4 months of the final internal denial	45 calendar days, or 72 hours if expedited
File a grievance about how you were treated	Any time	Acknowledged in 5 business days, resolved in 30 calendar days

You may name someone — including your provider — to act for you in writing. Section 9 of NCH-EOC-2028 sets out the full procedure and controls.

WHAT YOU CAN DO, AND WHAT ONLY YOUR PROVIDER CAN DO

TASK	YOU	YOUR PROVIDER	NORTHCREST
Submit a referral	No	Yes — your PCP's office	Records it within 2 business days
Submit a prior authorization request	No	Yes — the ordering provider	Reviews within the timelines above
Check status	Yes — portal or 1-800-555-0214	Yes — provider portal	Answers on the call
Send missing clinical records	No — they must come from the clinical record	Yes	Tells the provider exactly what is missing
Request expedited handling	Yes	Yes	Decides whether the expedited standard is met
File an appeal	Yes	Yes, with your written authorization	Acknowledges in writing
Confirm a provider is in network on a date	Yes — portal or 1-800-555-0210	Yes	Confirms network status, which is separate from authorization
Decide whether a service is right for you	With your clinician	With you	**No — the plan does not make treatment decisions**

Controlling document: The Evidence of Coverage for this plan, form NCH-EOC-2028, is the controlling document. Where anything in this guide differs from the Evidence of Coverage, the Evidence of Coverage governs. Nothing here creates a benefit, and an approval, referral, or estimate is never a guarantee of payment.