www.accesswv.org
A program of the State of West Virginia

**CALL:** 1 (866) 698-3515
**FAX:** 1 (866) 938-0353
**MAIL:** ActiveHealth
PO Box 221138
Chantilly, VA 20153-1138

## REQUEST FOR PRIOR APPROVAL OF OUT-OF-STATE OR OUT-OF-NETWORK SERVICES

| | | |
|---|---|---|
| **Policyholder Name**: | **Policyholder ID #** | |
| Street Address: | | |
| City: | State: | Zip: |
| Home Telephone | Work Telephone: | |
| | | |
| **Patient Name**: | Relationship to Member: | |

| | |
|---|---|
| **Referring Physician:** | Telephone: |
| Address/City/State/Zip: | |
| | |
| **Services Requested for Approval and Reason for Request** (please include a description of the proposed services and the specific reason(s) for care being requested out-of-state or out-of-network, including past treatment done locally if applicable): | |
| _____ | |
| _____ | |
| **Provider/Facility requested:** | |
| Specialty: | Telephone: |
| Address/City/State/Zip: | |
| **Date of Appointment or Procedure (if scheduled)**: | |

| |
|---|
| **By signing below, I am requesting prior approval for the provider, facility, and services listed and I am authorizing release of information to ActiveHealth.** |
| **Authorization to Release Information:** |
| I authorize |
| (Provider's Name) |
| |
| (Provider's Address/City/State/Zip) |
| to release to ActiveHealth all information relating to past, present, and future health care examinations, conditions, and treatments for: **NAME:** |
| *(If patient is younger than 18 years of age, policyholder/legal guardian must sign this form to authorize the release of medical information)* |
| |
| **Request for Prior Approval:** |
| **Patient/Parent/Guardian/Representative Signature:**_____ |
| **Relationship:** _____**Date:**_____ |

**Please see back page for important information**

**Please Note:** Receiving services from a provider who is outside the state of West Virginia will increase your co-insurance (i.e., your share of cost); receiving out-of-state services without Prior Approval will increase your share of cost plus expose you to the provider's balance billing of charges not paid by insurance.

| Provider | | Prior Approval | Co-insurance After Deductible | |
|---|---|---|---|---|
| In-state | In-network | | 20% | |
| Out-of-state | In-network | Prior Approval | 30% | |
| Out-of-state | In-network | **No** Prior Approval | 40% | + balance billing |
| Out-of-state | Out-of-network | Prior Approval | 40% | |
| Out-of-state | Out-of-network | **No** Prior Approval | 50% | + balance billing |

**ALL INFORMATION MUST BE PROVIDED TO AVOID DELAY IN PROCESSING THIS REQUEST**