Prior Authorization Fact Sheet

Additional information about Prior Authorization is available in your Certificate of Coverage which can be found at www.commongroundhealthcare.org/coverage-details . If you would like a copy of the Certificate of Coverage, you may request that one be mailed to you by calling 877.514.2442.

Providers that participate in CGHC's network aware of CGHC's Prior Authorization policy and will generally obtain authorization before they provide the services that require it. However, it is ultimately your responsibility to ensure Prior Authorization was obtained. If you have not received a Prior Authorization determination notice from us, please contact us BEFORE receiving health care services at 877.514.2442 to verify that your hospital, physician or medical providers are in-network and that Prior Authorization has been obtained. Our Member Services Representatives can tell you whether the Prior Authorization is approved, denied or is still pending as of 48 hours prior to the time you call.

Once you have obtained the Prior Authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the Prior Authorization. Important facts:

- A Prior Authorization request must be received by us at least 15 business days prior to the anticipated date of your service/procedure. In urgent or emergency admissions, Prior Authorization must be obtained within 48 hours of the admission.
- Out-of-network care is generally not covered under our individual health plans except for emergency care, urgent care outside of our 20 counties or with an approved referral. If you get CGHC insurance through your employer, out-of-network care may be covered. In any case, it is your responsibility to contact us for Prior Authorization if you seek care out-of-network. A referral approved by CGHC is not the same as a prior authorization and in some cases, you need both.
- Please note that a verbal request for Prior Authorization does not guarantee approval. We will notify you in writing of the decision regarding a determination for outpatient services. If your Provider determines that additional care beyond the services specified or the length of time originally authorized is medically indicated, your doctor must request an extension of the original authorization. You and your Provider will be notified whether the request for an extension is approved or denied.
- If you fail to obtain written Prior Authorization for designated services, eligible expenses will be reduced by 50% up to a maximum penalty of $1500 per service. The 50% reduction or penalty amount will apply first, before a deductible, coinsurance, or any other plan payment or action, and does not apply toward your deductible, coinsurance or maximum out-of-pocket.
- Prior Authorization must be obtained regardless of whether Common Ground Healthcare Cooperative is your primary or secondary health insurance carrier. Prior Authorization does not guarantee coverage and/or payment if a benefit maximum has been reached or coverage has been terminated.

A Prior Authorization is not a guarantee benefits will be paid. It is a determination that the services meet the definition of Medical Necessity. We authorize services or supplies based on the information that is available at the time of the authorization. If the bill that is submitted does not match the service authorized, the service may not be paid. The authorization does not guarantee a Covered Person's eligibility or Benefits under this Certificate. We make Benefit determinations in accordance with all the terms, conditions, limitations and exclusions of this Certificate. Your Policy must be in effect at the time services are rendered.