# OHIO REPRODUCTIVE MEDICINE
## REFERRAL WAIVER

We, in the Billing Department at ORM, want to see that you obtain the highest benefit level from your insurance company. It is very important for you, the patient, to become familiar with your insurance plan and how it works. Some insurance plans require you to obtain referrals. Referrals are essential to receiving the maximum benefit from your insurance company. In most cases, if a referral is not on file, payment will not be made.

Some plans only require an initial referral from your referring physician. The referring physician is your Primary Care Physician (PCP), not your OBGYN. Other plans require that you continuously carry a referral for all services, making it necessary to update them frequently. In some cases, referrals or preauthorization is required only for certain procedures.

We suggest that you contact your insurance company prior to your first visit and familiarize yourself with your plan and its requirements. Some insurance companies have a department dedicated to infertility treatment. You can inquire with customer service and ask to be connected. The infertility department would be knowledgeable in the process of infertility treatment and very helpful.

If at any time you have any questions regarding any of this information or any other insurance/billing issue, please do not hesitate to contact our Billing Department at (614) 451-2280. Our office hours are Monday - Friday from 8:00 a.m. to 4:00 p.m.

**You are responsible for making sure that referrals are in place for the services you receive. You will be held responsible for claims not paid by your insurance company if no referral is on file.**

I have read and understood the above information. I realize that I am responsible for assuring that required referrals have been obtained throughout the entire course of my treatment. Should my claim(s) be denied for no referral or authorization, I accept that I will be held financially responsible for all service(s) provided. – **Not all referrals cover all expenses.**

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PATIENT NAME: ______________________________________________
(please print)

PATIENT SIGNATURE: ______________________________ DATE: ______________