

\_\_\_\_\_  
ASH Contracted Provider

\_\_\_\_\_  
Address

**Plan Requirement Acknowledgment:**

I, \_\_\_\_\_ acknowledge that I have been advised that my health plan  
(Name of Patient/Member/Guardian)

\_\_\_\_\_ through my employer,  
(Name of Health Plan)

\_\_\_\_\_ requires a Primary Care Physician referral for  
(Name of Employer Group)

coverage of treatment/services with this provider.

I understand that my plan requires a Primary Care Physician referral before I access Covered Services and if I have not already obtained a referral as prescribed under the terms of my employer's Medical and Hospital Subscriber Agreement or Insurance Policy, I am liable for the charges listed below for covered services rendered. If the required referral condition is not met, I agree to pay in full for all services listed below within thirty (30) days of receiving a bill from the above Contracted Provider or health plan.

<u>Date</u>	<u>Services Rendered</u>	<u>Charge</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

\_\_\_\_\_  
Date Signature of Member (Or Subscriber)

\_\_\_\_\_  
Date Provider Signature

Note to Contracted Provider's Office Personnel:

Please keep the original copy of the completed Member Plan Requirement Acknowledgment form in the member's file. If you need to submit this form to ASH, please send it to ASH at the address above. If you have any questions, call ASH Provider Services at 800.972.4226.