

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 66**

POLICY TITLE: GENERATING LETTERS TO SUBSCRIBERS FOR RETROACTIVELY APPROVED CLAIMS.

PURPOSE: To educate enrollees of the need to have prior authorization for services received out of Plan.

PROCEDURE:

1. Case Manager will review the claim and do research as indicated such as medical record review, verification from referring practitioner, etc.
2. Once it is determined that this is a missed referral, the Case Manager will document the referral authorization in the information system and notify claims person to pay according to enrollee's contract.
3. For out-of-area claims reviewed and deemed appropriate, the Case Manager will approve and document in information system. Claims staff will be notified to pay according to terms of the contract.
4. A letter will be sent to the subscriber stating that the claim was reviewed by Health Care Services staff and approved to be paid according to the terms of the contract.
5. Copy of letter will be kept in the Health Care Services Department file.
6. See attached flow chart.

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Manager of Health Care Services/Quality Improvement

Date

Mary Leary, R.N.
Director of Health Care Services/Quality Improvement

Date

Original: 06/96	Revised: 05/00	Reviewed: 03/04	Reviewed: 03/08
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