Blue Care Network of Michigan

Understanding prior authorizations for your point of service plan

Blue Elect Plus℠ POS and Blue Elect Plus HSA℠ POS

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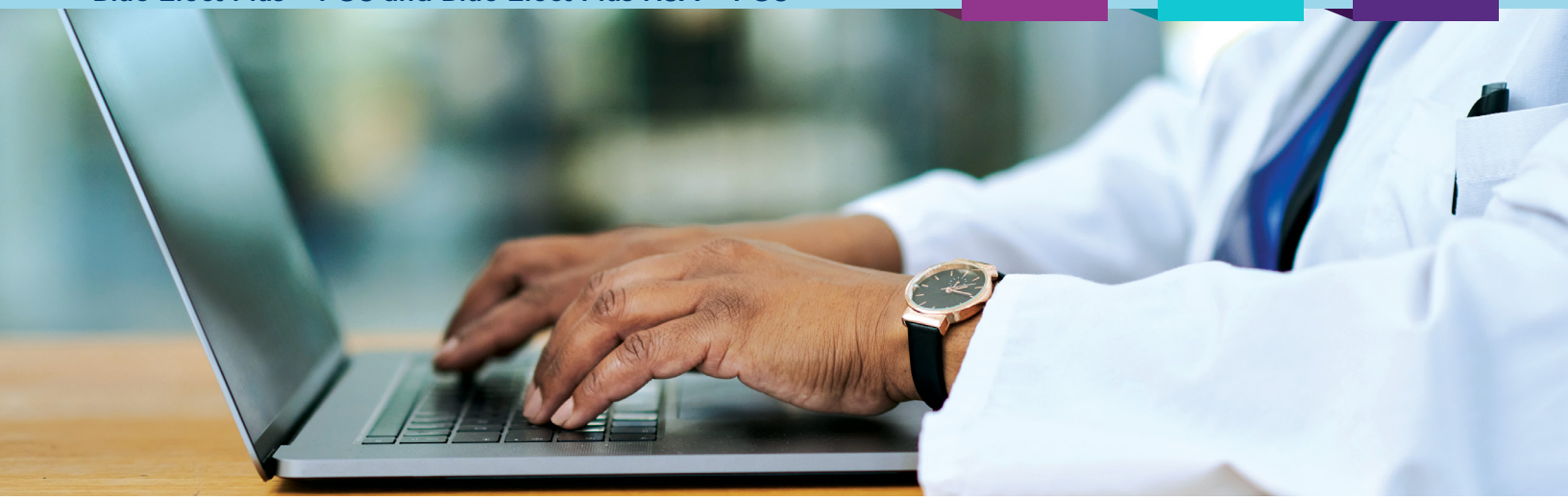

What's a prior authorization?

If you've ever been to the doctor and needed certain health care services or prescription drugs, your doctor may have told you that your health care plan needs to authorize the service. A prior authorization is special approval from us for certain services, such as hospitalization, certain radiology services and outpatient therapy.

Why do some services need prior authorization?

In some cases, we require authorization to make sure what's being requested is appropriate for your condition and medically necessary. A prior authorization may be required for certain prescription drugs, medical tests, surgeries and other health care services. Your plan may also have requirements about where to get certain services.

What services need a prior authorization?

The following is a partial list of health care services that need prior authorization. **Once you enroll, you can check your online member account or call the number on the back of your member ID card for a complete list. Or check with your doctor to see if prior authorization is required for a health care service.**

- Musculoskeletal services, including pain management
- Sterilization procedures
- Chiropractic services
- Cosmetic procedures, such as removing scars or excess tissue from your eyes or abdomen
- Experimental procedures
- Gender reassignment surgery
- Inpatient care
- Investigational procedures
- Mental health or substance use disorders: inpatient hospitalizations, intensive outpatient services, partial hospitalization services and treatment in a freestanding substance use disorder facility
- Physical, speech and occupational therapy
- Skilled nursing facility care
- Transplant services, including those for organ, bone marrow and stem cell transplants

Who's responsible for submitting a prior authorization?

For in-network services, the doctor coordinates the authorization process. **When you see a doctor who's not in network, you're responsible for having the out-of-network health care provider call the number on the back of your member ID card to request authorization.** We'll begin the review process once we receive the request.

What if my prior authorization request is denied?

If the authorization request is denied, you have the right to appeal the decision. You'll receive a letter that says your request was denied and the reason, plus information that explains how you can appeal.

Once you enroll, register your online member account at bcbsm.com/register. Use your account to check if your prior authorization has been approved or denied.