American Specialty Health (ASH)
P.O. Box 509001 San Diego, CA 92150-9001
Fax: 877.248.2746

MEMBER PLAN REQUIREMENT ACKNOWLEDGMENT

For questions, please call ASH at 800.972.4226

_____
ASH Contracted Practitioner

_____
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 practitioner.

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 Practitioner or health plan.

Date	Services Rendered	Charge
		$
		$
		$
		$
		$

_____ _____
Date Signature of Member (Or Subscriber)

_____ _____
Date Practitioner Signature

Note to Contracted Practitioner'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 Customer Service at 800.972.4226.