Out-of-Network Referral Form

Referrals to out-of-network providers must be authorized before the service.
Call (616) 464-6619 or (800) 638-0573 Fax (616) 464-4465
Mail claims to ASR Health Benefits, P.O. Box 6392, Grand Rapids, MI 49516-6392

I. PATIENT INFORMATION:

a. Patient Name: _____

b. Date of Birth: _____ c. Patient is: Member Spouse Dependent

II. MEMBER INFORMATION:

a. Member Name: _____

b. Member's Employer: _____ c. Member ID Number: _____

d. Member accepts financial responsibility for out-of-network referral? Yes No

III. OUT-OF-NETWORK PROVIDER:

a. Provider Name: _____

b. Address: _____ c. Phone Number: _____

d. Specialty: e. Appointment Date: