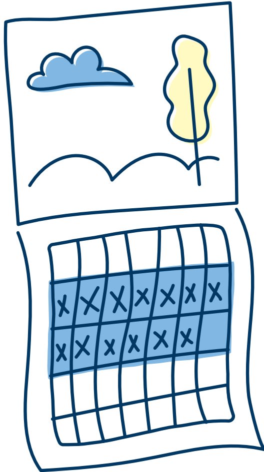

Prior authorization for out-of-area services

You are required to confirm that your provider obtained a prior authorization for any out-of-area services requiring authorization *in advance of receiving the service.* Beginning Aug. 8, 2021, this will also include advanced radiology and cardiac imaging. A prior authorization just means that we work with your provider before you receive the proposed service to make sure that the procedure is medically necessary. Your out-of-area provider will be expected to reach out to us about that, but it is important that you stay in contact with them.

If no prior authorization is received, you could be responsible for 100% of your bill.*

Call Member Service, the number on the back of your identification card, to review your coverage and confirm if you need your provider to get a prior authorization.

*A prior authorization is not a guarantee of coverage, payment, or payment amount. All services are subject to contract exclusions and eligibility at the time the service is rendered.

Let's break this down a little more.

1. You and your provider agree on a service that you need.
2. Your provider lets Highmark know all of the details about the procedure. **You should stay in contact with your provider.**
3. Highmark will review your requested service.
4. We'll send you and your provider a prior authorization if the request is determined to be medically necessary.