Referral to Outside Laboratories, Facilities, and/or Providers

The purpose of this form is to make sure your testing goes to the correct participating laboratory based on your insurance coverage.

I acknowledge that in the course of my treatment, RMA NORCAL may refer me to other health care facilities and/or providers for diagnostic tests, x-rays, procedures or consultation. RMA NORCAL agrees to notify me when such a referral is required. I understand that RMA NORCAL does not know whether that Facility or Provider that are referring me to is a participating provider of my insurance plan.

I agree that should RMA NORCAL make such a referral**, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the outside Facility or Provider that RMA NORCAL refers to contracts with my health insurance plan.** RMA NORCAL is not responsible should my health insurance plan process claims at the non – contracted level for the referred services(s). I agree to be financially responsible for either the full amount or the balance after payment by my health insurance plan should the claim be denied or processed at a lesser benefit level.

RMA NORCAL commonly refers to the following outside laboratories; Quest Diagnostics, Lab Corp, Counsyl, Genzyme Genetics. Please note: all Blue Cross, United, and Oxford Health Plans patients' lab work must be sent to Lab Corp. Aetna patients must utilize Quest (if having blood work done at an outside lab). If my insurance requires a different lab I understand that I need to obtain a script from RMA NORCAL and have my blood drawn at the designated facility required by my insurance carrier.

RMA NORCAL commonly refers to the following outside *facilities*; Berger, Hirsch & Ratakonda Radiologists, University Radiology, and Warren Imaging Center Associated Radiologists.

Counsyl is a specialty laboratory that RMA NORCAL recommends for genetic testing such as Cystic Fibrosis, Ashkenazi Jewish Panel, Thalassemia, SMA testing and further evaluation for male factor infertility. Some of this complex testing is only performed at these labs, so please call your insurance company for further information about your coverage.

Patient	**Partner (if applicable)**
Name (Print): _____	Name (Print): _____
My preferred laboratory is: _____	My preferred laboratory is: _____
Signature: _____	Signature: _____
Date: _____	Date: _____