Understanding your health insurance policy and payment practices

As a patient, you should be involved in your medical treatment and in paying for your health care. This flyer will help you understand your health insurance policy and the health care payment process.

Our staff follows the rules of your health insurance policy. The office staff works hard to send bills on time to your health insurance company for payment so you will not have to pay for medical care covered by your health insurance. In some cases, our staff may ask for your help when bills are sent to your health insurance company to make sure your bills are paid on time.

Ten frequently asked questions about paying medical bills

1. What is a health insurance policy?

Your health insurance policy is a contract between you and your health insurance company. It is an agreement that your health insurance company will pay for covered medical care as long as your premium is paid. The health insurance company may not pay for every bill. This is why it is important for you to know which medical treatments the health insurance company will pay for and which expenses it will not cover. You are responsible for paying any medical costs that the health insurance company does not pay for.

2. What are some common insurance terms I should know?

Be sure to check with your health insurance company to see how these terms apply to your health insurance coverage.

- **Co-payment or "co-pay"** The part of your medical bill you must pay each time you visit the doctor. This is a pre-set fee determined by your health insurance policy.
- **Co-insurance** The part of your bill, in addition to a co-pay, that you must pay. Co-insurance is usually a percentage of the total medical bill—for example, 20%
- **Deductible** The cost you must pay for medical treatment before your health insurance company starts to pay—for example, $1,000 per individual or $4,000 per family. In most cases, a new deductible must be satisfied each calendar year.

- **Non-covered charges** Costs for medical treatment that your health insurance company does not pay. You may wish to determine if your treatment is covered by your health insurance policy before you are billed for these charges by the doctor's office.
- **Approval number** A number authorizing the health insurance company to pay benefits for your care. You may need to obtain an approval number from your health insurance representative before you see the doctor in order for the health insurance company to pay for your medical treatment.

3. How is my doctor's office paid?

You should pay your co-payment and deductible, if required, during your visit to the doctor. While you are responsible for your medical treatment, we will make every effort to seek payment from your health insurance company for the amount owed under your policy. The process by which the office seeks payment is very complicated, which is why we need correct information from you.

4. What information should I bring to the doctor's office?

- Photo identification, such as a driver's license or passport;
- Your current health insurance card; and
- Any change in personal information such as your name, address, employer or phone number.

5. Why does the doctor's office need my personal and health insurance information to get paid?

The doctor's office staff uses this information to confirm your health insurance coverage and to send your health insurance company a request for payment of your medical bill. The health insurance company requires your personal and health insurance policy information before it will pay your bill. Be sure the doctor's office staff has your current health insurance policy information, including the health insurance company name and address, policy number, group number, etc., so the health insurance company can pay your medical bill on time. Much of this information may have changed since your last visit to the doctor. The services covered by your health insurer also may have changed. That is why many doctors' offices require you to provide this information at each visit.

6. What is a "coordination of benefits" form?

Many health insurance companies require you to fill out a form that tells the company whether you or another family member have other health insurance. Your health insurance company needs this information to work with other insurers to determine which company pays for what service. It is important that you fill out this form and return it to the health insurance company. Otherwise, your medical bills may not get paid or payment may be delayed.

7. Why does my health insurance company require a prior authorization?

Your health insurance company uses a prior authorization requirement as a way of keeping healthcare costs in check. It wants to make sure that the service or drug you are requesting is truly medically necessary.

8. What if the health insurance company does not pay or pays only a portion of my medical bill?

The billing office staff will contact the health insurance company to ask why the medical bill was not paid. The health insurance company may ask the staff to appeal or re-send the medical bill with more information. This typically happens when the health insurance company has not paid for a procedure or service listed on your bill even if your doctor said it was medically necessary. You may receive a copy of your doctor's appeal letter to your health insurance company.

The doctor would like your help to get the medical bill paid when your health insurance company does not pay. You may be asked to call your health insurance company or your employer to ask why your medical bill has not been paid.

9. Why / When does my healthcare provider contact me related to the payment issues from the health insurance company?

Your healthcare provider will submit the claim for the services rendered to you to your insurance company. Based on the response from the insurance company, your healthcare provider may contact you for one of the following scenarios:

- Your insurance company will not process payment if you have not completed your coordination of benefits form (see #6 above) or other required health insurance forms. You will be required to call your insurance company and complete the required information.
- Your health insurance premium has not been paid due to which insurance company denies the payment. You will need to ensure the payment is made and the same is updated with the insurance company or provide the details of the any other insurance company if you have.
- The policy provided by yourself was not active at the time of services or became inactive retroactively. This could be either primary or secondary insurance policy that you hold. You will be asked to provide details of the active insurance policy.
- Your insurance company denies payment to the healthcare provider based on the reason that you have a HMO plan or other primary insurance. You will be asked to provide the details of the other insurance or update the records with existing insurance company.
- Medical treatment provided to you is not covered by your insurance policy. Healthcare provider will contact you to verify if you have any other policy that covers the treatment.
- Insurance company has denied payment based on discrepancies in your demographic information. Your healthcare provider may call you to verify the information.

- The doctor is "out-of-network," which means your doctor does not have a contract or agreement with your health insurance company. If your doctor refers you to another doctor, be aware that if the referred doctor is "out-of-network" you may be responsible for a portion of the payment

10. What do I do if my insurance coverage has changed?

- To ensure prompt payment of your claim, please make sure your health care providers have your most up-to-date insurance information. Always bring your insurance card with you to medical appointments.