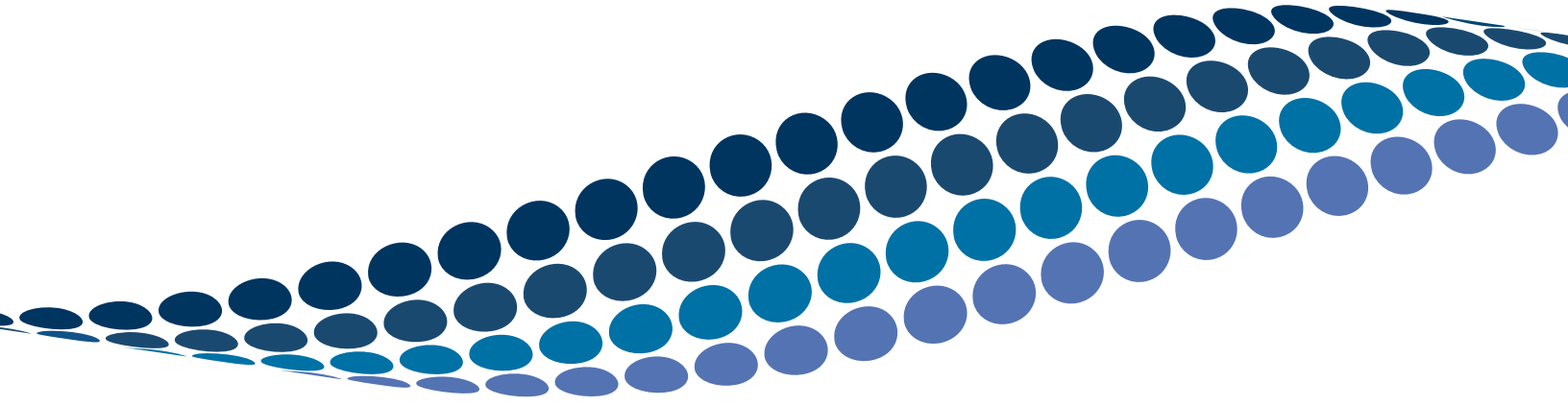
JEFFERSON RADIOLOGY

Billing Terms & FAQS

Our Billing Department can be reached at 1-866-772-8117:
Monday through Thursday 8:30AM - 3:30PM
Friday 8:30AM - 1:00PM

For inquiries related to procedural pricing:
860-289-3375 extension 88276



FAQS

What is a deductible?

Deductibles are provisions that require the member to accumulate a specific amount of medical bills before benefits are paid. For example, if a member's policy contains a $500 deductible, the member must accumulate and pay $500 out of pocket before the insurance carrier will pay benefits. Once the patient has met their deductible, the carrier usually pays a percentage of the bill. The patient is liable for the unpaid percentage. Deductibles are yearly, usually starting in January.

What is co-insurance?

Co-insurance is a form of cost-sharing. After your deductible has been met, the plan will begin paying a percentage of your bills. The remaining amount, known as co-insurance, is the portion due by the patient.

Why did my insurance company only pay part of my bill?

Most insurance plans require you to pay a deductible and/or co-insurance. In addition, you could be responsible for non-covered services. Please contact your insurance company for specific answers to your questions. You may have out-of-pocket expenses.

Why do I need to call the insurance company if they do not pay my bill?

If you have a PPO policy, you are ultimately responsible for the total bill or any portion of the bill your insurance carrier does not pay. The Central Billing Office will make every effort to resolve the account balance with your insurance carrier. Occasionally, we will be unable to resolve the issue with your carrier and will need your assistance.

If I have an HMO policy, can I be billed if they do not pay?

If you have an HMO policy, you should only be billed for the amount specified on your explanation of benefits (EOB) that is provided to you by your insurance carrier. This usually includes co-pay amounts, deductibles and non-covered services.

I belong to a managed care plan. What should I do before I have services?

Read your insurance plan booklet to be sure you have followed all the guidelines for referrals and authorizations or call your insurance for assistance. Failure to follow your plan requirements may result in greater out-of-pocket expenses for you. Your primary care physician plays a very important role in this process. If you receive a verbal authorization number, please be sure to let us know that number prior to your exam so we may verify it for you. Obtain all insurance quotes in writing.

Terminology

A

Allowed Expenses
The maximum amount a plan pays for a covered service.

Assignment & Authorization
A form signed by the patient showing insurance plans assigned and their billing priority. This form allows our practice to bill insurances on the patient's behalf and receive payment directly from the payer. Signature on the form also authorizes the release of medical information to the patient's Ordering Physician, so their physician can further treat them.

B

Benefits
These are medical services for which your insurance plan will pay, in full or in part.

Beneficiary
Someone who is eligible for or receiving benefits under an insurance policy or plan.

Beneficiary Liability
The money amount beneficiaries must pay to providers for covered services. Beneficiaries also are responsible for paying any amounts deemed they're responsibility for their share of the benefits plan and premium, but this is not included in estimates of beneficiary liability.

C

Claim
A notice to the insurance company that a person received care covered by the plan. A claim is also a request for payment.

Co-Insurance
A type of cost sharing where the beneficiary and insurance company share payment of the approved charge for covered services in a specified ratio after payment of the deductible by the insured. For example, the insurance company agrees to pay 80% of covered charges then the patient picks up the 20% remaining balance.

Co-Payment
A set fee the member pays to providers at the time services are provided. Co-pays are applied to emergency room visits, hospital admissions, office visits, etc. The cost is usually minimal. The patient should be aware of the co-payment amounts prior to services being rendered. Your insurance company can assist you with these designated amounts.

Coverage
What services the health plan does and does not pay for.

Covered Expenses
What the insurance company will consider paying for as defined in the contract. For example, under some plans generic prescriptions are covered expenses while brand name prescriptions are not.

D

Date Of Service (DOS)
The date(s) healthcare services were provided to the beneficiary/patient.

Deductible
A portion of the covered expenses (typically $100, $200, $500 or Higher) as determined by your insurance plan, these amounts very by plan. This is the amount an insured individual must pay before insurance coverage with co-insurance goes into effect. Deductibles are standard in many policies, and are usually based on a calendar year.

E

Enrollee
The person who is covered by health insurance.

Experimental Procedures
Any health care services, that are determined by the insurance plan to be either; not generally accepted by informed health care professionals in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed; or not proven by scientific evidence to be effective in treating the condition for which it is proposed.

Explanation of Benefits (EOB)
The coverage statement sent to covered persons listing services rendered, amount billed and payment made. This normally would include any amounts due from the patient, as described in “Beneficiary Liability,” “Co-insurance,” “Deductible” and “Co-payment” all listed above.

G

Global Services

The global charge refers to both Professional (Reading) and Technical (Taking) Components when billed together. For services furnished to hospital outpatients or inpatients, the physician may bill only for the professional component (see below), because of the Technical Component (see below) Medicare statute that requires payment for non-physician services provided to hospital patients be paid only to the hospital.

M

Maximum Out of Pocket

The most money you can expect to pay for covered expenses. The maximum limit varies from plan to plan. Once the maximum out-of-pocket has been met, the health plan will pay 100% of certain covered expenses.

N

Network

Physicians, hospitals, and other health care providers that an HMO, PPO or other managed care network has selected to provide care for its members.

Non-Participating Provider (Non-Par)

Also known as out-of-network provider. A healthcare provider who has not contracted with the carrier of a health plan to be a participating provider of health care.

O

Open Enrollment

A specified period of time in which employees may change insurance plans and medical groups offered by their employer and have the new insurance effective at a later date.

Out of Network (OON)

Coverage for treatment obtained from a non-participating provider. Typically, it requires higher patient payment of a deductible and higher co-payments and co-insurance than for treatment from a participating provider. Insurance may also deny the entire bill.

Out-of-Pocket-Costs/Expenses (OOPs)

The portion of payments for covered health services required to be paid by the patient, including co-payments, co-insurance and deductible.

P

Pre-Admission Certification (PAC)
A review of the need for inpatient hospital care, completed before the actual admission.

Participating Provider
A provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility or a physician who has contractually accepted the terms and conditions as set forth by the health plan.

Point-of-Service Plan (POS)
Managed care product that offers enrollees a choice among options when they need medical services, rather than when they enroll in the plan. Enrollees may use providers outside the managed care network, but usually at higher cost. (This should not be confused with POS as used in retail pharmacy, where it stands for point of sale.)

Pre-Authorization
An insurance plan requirement in which you or your primary care physician need to notify your insurance company in advance about certain medical procedures (like outpatient surgery) in order for those procedures to be considered a covered expense.

Pre-Certification
Authorization given by a health plan for a Member to obtain services from a health care provider, most commonly required for hospital services. Members should refer to their insurance identification card or call their health plan to obtain information regarding pre-certification requirements.

Premium
Amount paid periodically to purchase health insurance benefits.

R

Referral
Approval or consent by a primary care physician for patient referral to ancillary services and specialists.

S

Subscriber
The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in an HMO or other health plan.