

## Frequently Asked Insurance Questions

### **I have a change in my contact information or insurance company. What next?**

Please notify the practice immediately of any changes in your information and/or insurance information. Not having correct information will prevent your claim from being filed to the appropriate insurance company. If it goes to the wrong insurance company, they will put the entire amount of the claim as your responsibility, and you will receive a statement from the practice. Please understand we do not want you to be responsible for a bill that your current insurance company should pay based on your contract with them.

### **I have a newborn and I don't have an insurance card yet. What do I do?**

Please notify the office as soon as you receive your newborn's insurance information. Depending on how long it takes for you to receive your newborn's information, you may receive a statement. As soon as the practice receives the insurance information, we will send all your claims to the insurance company. You will only receive a statement after the claims process, if you have patient responsibility based on your contract with the insurance company. In some circumstances, we might send the initial claim to your insurance company even though your child hasn't been added after the visit, just to have the claim on file in a timely manner.

### **I received a statement that my child has reached max visits allowed. Why?**

Certain insurance companies have a maximum of well child visits they allow in a year. This pertains to a certain age group, in the first few years of your child's life. If your provider deems this visit medically necessary, they will ask you to schedule it; however, they will not know if your insurance company has a limit. This does not apply to children past a certain age that will only need one well visit a year. In addition, a few insurance companies require you to wait 366 days between physicals from 3 years and up. Most insurance companies allow one physical in any calendar year no matter what month. It is your responsibility to understand what your insurance company policy states.

### **Why am I being billed for a hearing or vision test?**

Some insurance companies follow their own protocols and decide to only cover these tests every other year or not at all. Our providers practice the best quality medicine and follow the standards with guidance from the American Academy of Pediatrics. It is impossible for us to know each insurance company's decision on these tests. If you have any questions about what your policy allows, you should contact your insurance company.

### **Why am I being billed for developmental or behavioral screening forms?**

Our providers care about your child and want to provide the highest quality of care possible. In doing so, they follow the guidelines and recommendations of the American Academy of Pediatrics with regards to preventative health. This includes screening for development, behavioral and mental health. At every well visit, the doctor asks questions to see if there are any of these issues. However, it is also recommended that we use screening tools periodically to screen for these types of issues as well. This provides you and us with the confidence that there is no development, behavioral or mental health issues that need to be addressed. Getting services or treatment for these issues as early as possible gives the child the best chance to improve. Most insurance companies pay for these screenings, however, (even though your insurance company does agree it is a service that should be paid) they say it is your responsibility. We are sorry that your insurance company made that decision, but we need to do what's best for your child.

### **Why am I being billed for services provided on weekends and evenings?**

Insurance companies want primary care physicians to remain open later in the evening and on weekends to provide access to great quality medical care during hours where patients frequent Emergency Rooms and Urgent Care Centers. Most insurance companies are paying physicians to see patients during these hours. Unfortunately, some insurance companies make a portion of this payment your responsibility. It is your responsibility to know your benefits.

### **What is a coordination of benefits (COB) request?**

A provision in the contract that applies a person is covered under more than one medical plan (do you have two insurance policies covering the child); you need to contact your insurance company as soon as possible. They will not pay for your claim until they have verified this information.

### **What is a copayment?**

A cost sharing arrangement in which an insured pays a set amount for a specified service, such as \$25 for an office visit, Copayment is paid at the time of service per your contract with the insurance company. Many insurance companies do not apply copayment to the well visit, however, sometimes there are tests performed or an issue/illness that goes above and beyond what a well visit entails. In this instance, your insurance company might require you to pay a copayment even during the well visit.

### **What is a coinsurance?**

The portion of covered health care costs for which the insured has a financial responsibility, usually a fixed percentage rate once the insured meets his/her deductible.

### **What is a deductible?**

A deductible is a yearly amount a covered person or family pays each year from his/her own pocket before the plan will make payments for services rendered.

### **What is an out of pocket maximum met?**

The yearly maximum dollar amount that is the insured responsibility. If you meet your max out of pocket amount, your plan will pick up the full amount of your care.

### **What is a benefit maximum met?**

A benefit maximum is the total amount an insurance company will pay out for your care. If you reach benefit maximum, the insurance company will no longer pay any of your claims. They will be a patient responsibility.

### **What is an explanation of benefits (EOB)?**

That is a statement sent to an insured by their insurance company listing services provided, amount billed, eligible expenses paid by the health insurance company to the provider, and patient responsibility.

### **What is a participating provider?**

A participating provider is a medical provider who has been contracted to render medical services at a pre-negotiated fee. This is a contract only between insurance companies and providers not subscribers and providers.

### **What is an out of network provider?**

An out of network provider is a health care provider with whom an insurance company does not have a contract to provide health care services. The insured must pay either all or most of the cost, depending on the insured policy for out of network providers.

### **What is the point of service (POS) plan?**

This is similar to the HMO. However, you can go out of network. The plan usually covers less financially if you go out of network.

### **What is preferred provider organization (PPO)?**

The main concept behind a PPO is the network. If you opt for this type of insurance, you may choose any healthcare provider from within your network, determined by your policy.

### **What is health maintenance organization (HMO)?**

An HMO will not pay for services you receive outside the network. Your primary care physician acts as the gatekeeper to your health care. In order to obtain specialty care, you must attain a referral from your PCP.

### **What is a primary care provider (PCP)?**

A physician that is responsible for providing primary care, prescribing, authorizing and coordinating all medical care and treatment. It is your responsibility to make sure you select our doctor as your primary care provider. Failure to do so, might result in the claim being denied and ultimately become your responsibility.

### **How to make a payment?**

Payments can be made the following ways:

At the time of the visit: You can pay with cash, check or credit card. You can also leave a credit card on file for future visits. Mail in the statement: You can mail in the statement with a check or credit card information to the address on the statement. Pay by phone: You can call the doctor's office or the phone number on the statement to make a payment by credit card. Pay online: You can pay online via the alliedphysiciansgroup.com website

### **Why did I get a copay for a "follow up" visit?**

All visits are billable and therefore will cause a copay, coinsurance, or deductible payment based on your contract with your insurance company.