Best practices to help improve Patient AR & Collections:

- **Insurance Fee Schedules** should be updated at the beginning of every year (these are the contracted fees for your in network plans -- call insurance in January and request current fee schedule, enter into your dental software and keep on file). This helps improve your patient copay estimates.
- **Accurate Insurance Verifications:** Full breakdown of benefits should be obtained for all New Patients, Recall Patients, patients with new insurance and any patient not seen within the last 6 months. All other scheduled patients you should be verifying that their plan is effective & what their remaining benefits/deductibles are before their appointment. This should be completed before the patient is in the office 1-7 days in advance.
- **Accurate Data Entry for Insurance Verifications:** Once you have current information, make sure it is entered accurately & completely into your dental software. Scan in any supporting documentation (verification forms, faxback verifications, online verification breakdowns) into the patient chart. Always try to get a copy of the insurance card (front and back) and save in patient images.
- **Collect patient copays at time of service:** Provide your patients with accurate copay estimates and treatment plans in advance so they know what they should be prepared to pay at their visit. For New Patients -- after insurance has been verified & entered into their chart, you should provide them with their estimated copay before their visit. Existing patients should be given treatment plans and reminded of their estimated copay when confirming an appointment. At check in, the patient should be presented a tx plan of today's services with their estimated copay once again.
- **Keep Information Up to Date:** Make sure you always have the most recent patient contact information and insurance information. Any time you schedule an appointment you should be confirming their address/phone number/email and their insurance information. Always try to get new insurance information before the appointment day so you can verify the plan.

Basic System for Patient AR

- Patient statements sent every week for all patients with non-insurance balances (no open claims) that have not received a statement in the last 30 days. Account audit performed to determine source of balance & documented in patient chart.
- Patient statement sent within 1-2 days after their insurance claim has closed when they have a balance left over. We send you patient account numbers on our reports to let you know to send a statement.if you are enrolled in the Insurance AR Service. This is automatically done if enrolled in the Patient AR Service.
- Collection Calls & Letters: Patient AR should be worked in full once a month -- someone in the office prints the Aging of AR Report. Go through each patient on the report that does not have estimated insurance, review the account, determine where the balance is coming from and call the patient to collect. These should be "soft" collections meant to help resolve the balance & keep the patient in the practice. Make sure to document every phone call in detail in the patient chart. For offices with large Patient AR or unworked Patient AR, going through the full Patient AR may be broken down into aging categories for the first 3-6 months.
- Turn Patients Over to Collections or Write-off: After 90 days and at least 2 statements, 2 phone calls have been made, send the patient a final notice letter letting them know that after many attempts to collect that you will be turning their account over to collections which will affect their credit & incur an additional fee of 50% of their balance (whatever the collection agency charges you) if they do not contact the office within 10 business days. After 10 business days, report the account to the collection agency, mark the account as in collections/inactive. Once an account has been turned over to a collection agency, the office makes no further attempts to collect & should not continue seeing the patient. If the balance is under $100-$200 it's best to just write it off if you are unable to collect it instead of turning it over to a collection agency. Some offices will file small claims court claims instead of using collection agencies but the balance should be more than $1,000.
- Offices with unworked Patient AR for more than 3 months:
    - Send statements immediately to ALL accounts with a balance (even those with open insurance claims). If you have a very large amount of delinquent Patient AR (over 90 days), you may choose to send statements without auditing (determining where the balance is from)....BUT, keep in mind that in many cases this results in an influx of phone calls to the office asking about balances. This can be okay as long as you are prepared. You can complete account audits as the patient calls come in. If your Insurance AR is also delinquent, be sure that you have done your part correctly in filing the patient's claims before sending a statement or be aware that you may need to handle patient questions regarding their open claim.

Patient AR System Timeline

Daily: Send statements the same day for any patient accounts with a balance after an insurance claim is closed or patient left office without paying balance or estimated copay.

Weekly: Send statements to all patients without open insurance claims who have not received a statement within the last 30 days

Monthly: Work through the entire Patient AR list for any balances over 30 days aging & take appropriate action (collection call, collection letter, turn over to collection agency, write off, etc). If a patient has a large balance (over $250) or has a history of difficulty paying, do not wait until the balance is 30 days aging – start collections actions immediately. This task should be broken down into a weekly list so that the entire list is completed by the end of the month.

For accounts with balances that are between 0-30 days aging:

- Send statement immediately
- 2 Weeks After 1st Statement — Courtesy Reminder Collection Call
- 1 Week After Courtesy Reminder Call — 1st Collection Letter Mailed
- 1 Week After 1st Collection Letter — 2nd Collection Call
- 1 Week After 2nd Collection Call — Final Collection Letter Mailed (with notice of Collection Agency action if applicable)
- 2 Weeks after Final Collection Letter — Turn Over to Collection Agency if applicable or Bad Debt Write Off applied if applicable (balance should be at least 90 days aging)

For accounts with balances that are over 31 days aging:

- Send statement immediately
- 1st Collection Call completed within 1 week of statement sent
- 1 Week After 1st Collection Call — 1st Collection Letter Mailed
- 1 Week After 1st Collection Letter — 2nd Collection Call
- 1 Week After 2nd Collection Call — Final Collection Letter Mailed (with notice of Collection Agency action if applicable)
- 2 Weeks after Final Collection Letter — Turn Over to Collection Agency if applicable or Bad Debt Write Off applied if applicable (balance should be at least 90 days aging)