Frequently Asked Billing Questions

I paid when I checked in for my appointment. Why did I get a bill later for additional charges?
What you pay at check-in is usually only a partial payment i.e. copays, coinsurance or deductible, and may not cover the full charges for the services you receive. Your doctor may perform additional services (like a nasal endoscopy) during your visit, so the actual cost of your visit may be higher. If there are any additional charges, you'll get a bill for the difference later.

I'm covered under my insurance and my spouse's. The deductible is less under my spouse's insurance. Can you just bill his/her insurance and not mine?

Under a provision called Coordination of Benefits, we are obligated to bill the insurance that would be considered primary for you. Any medical insurance for which you are the primary holder must be billed before any other medical insurance.

Why am I getting different bills for one surgery or procedure?

If you have surgery, you may get separate bills from the surgery center, hospital or the anesthesiologist or from pathology for outpatient laboratory testing.

Who is responsible for getting an authorization or pre-approval for a particular service?

We will try to obtain authorization from your insurance company for services provided; however, it is ultimately your responsibility to ensure that services have been authorized or pre-approved. In some cases, insurance plans will not pay for hospital costs if patients do not pre-certify before arrival. In this case, you would be liable for that entire expense. Our filing of claims with your insurance company does not guarantee coverage or payment.

Why do I receive questionnaires from my insurance companies?

Insurance companies may need to gather additional information from policyholders before processing payments. Examples would be they need details about your injury to ensure it is not a liability case or they could need to coordinate benefits if you carry two insurances or have at one time. Therefore, these questionnaires should be filled out and returned promptly to your insurance company to prevent potential claim denial and non-payment.

What if Advanced ENT doesn't participate with my plan?

If you are a member of a healthcare plan with which we do not participate, you may still receive services at our facility. However, these services are considered "out-of-network" and may not be covered by your health plan. You will be responsible for paying the bill in full or for any balance not paid by your health plan. As a courtesy to you, we will initially bill health plans with which we do not participate, but you will be responsible for payment if the plan does not respond promptly to our bill.

How will I know if my insurance company has paid my bill?

After your insurance company has paid and/or processed its portion of your claim, we will send you a statement. This statement will indicate payments and adjustments that have been posted to your account and any balance you are required to pay. You should also receive an explanation of benefits from your insurance company.

I received a check from my insurance company. What do I do?

Some insurance companies send payment for medical services to the patient instead of the doctor. If you have already paid your doctor in full, then you should cash the check. If you have not paid your doctor you should:

- Contact your physician and inform them that you received a check from your insurance company.
- Find how much your account balance is.

You can sign the back of the check and send it to your doctor or you can deposit the check into your checking account and write a check to your doctor.

What's an Explanation of Benefits (EOB)?

An Explanation of Benefits is a document from your insurance company that shows how they processed your claim. It contains information such as co-pays, deductibles or non-covered services. EOBs should be kept for future reference.

What is a co-payment?

A co-payment is a set fee the member pays to providers at the time service is rendered. Co-pays are applied to emergency room visits, hospital admissions, office visits, etc. The fees are usually minimal. The patient should be aware of the co-payment amounts prior to service. Most times, co-payments are indicated on the patient’s insurance card.

What is co-insurance?

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

What is a deductible?

Deductibles are provisions that require the member to accumulate a specific dollar amount of medical bills before benefits are paid. Once the patient has met their deductible, the insurance usually pays a percentage of the remaining bill or bills. The patient is liable for the unpaid percentage. Deductibles are reset annually, usually starting in January. The status of your deductible can be found most often at times on your EOB or by calling the member services phone number on the back of your insurance card.

Why am I being asked for a deductible deposit when my card clearly states a co-payment on it?

Our practice has identified that you have a high deductible health plan and that your deductible has not been met. Until your deductible is met, the insurance will only process your claims at their 'allowed amount' and drop the balance they would have paid to the patient's responsibility. The co-payment is not active until the deductible is met. Since our Pre-Registration department verifies your insurance prior to seeing our providers and can validate your deductible status, Advanced ENT may ask for a deposit to apply to these services, since it is understandable that your financial responsibility from the claim will be much greater than a co-payment. The deposit amount is applied to your balance and you may still receive a statement for any remaining balances.

What is an 'allowed amount'?

An 'allowed amount' is the maximum amount of the billed charge an insurance company deems is payable by the plan. The insurance will base their payment to Advanced ENT and remaining patient responsibility based on their 'allowed amount'.

I received notice that my insurance company has paid part of my bill, but I don't understand how they calculated the payment amount. Can you help me?

For answers to any questions about insurance payments, deductibles, co-payments or how the insurance determines the payment, you should check with your insurance carrier.

Why am I being asked to contact my insurance company to get payment sent to Advanced ENT? Isn't that the practice's responsibility?

Occasionally we will experience difficulty obtaining payment and will ask you to help. There are many different reasons why an insurance company will withhold payment, and the insured member can usually help resolve these problems.

How do I follow-up with my insurance company?

Most insurance company ID cards have a customer service phone number on the back. Before you call, have available your insurance card, date of service, our practice's name, original billed amount, patient name and claim number if applicable. Write down the name of the person you talked with at the insurance company and ask for the reference # of the call. If the bill has not been paid, find out the anticipated payment date and ask what is needed. If the bill is not paid in the stated timeframe, follow-up with the insurance company again and, if necessary, request to speak to a supervisor. Other key questions you should ask the insurance company customer service representative include the following:

- Have you received the Advanced ENT's bill for these services?
- Am I covered for these services?
- When will you pay Advanced ENT for these services?
- What portion of this bill will I be responsible for paying?
- What is the status of the account? If paid, ask when and to whom.

Why didn't my insurance pay?

One or more of the following may apply:

- The medical attention you received was not covered under your plan.
- Your medical situation may not have met your insurance company’s definition of "medical necessity."
- Often the insurance company will cite a "non-emergent condition" as a reason for not paying. Your EOB should provide more specific answers to this question.
- The insurance information recorded at the time of service was inaccurate, incomplete or outdated.
- You were not covered by your insurance plan at time of service.
- Your primary care physician did not process a referral for the services or an authorization was not obtained prior to the services being rendered.
- Service received was from a physician/facility outside your plan's network.
- Your insurance is requesting information from you that they have not received.

What do I do if I disagree with how much my insurance company has paid on my bill?

If you have questions regarding the payment, call your insurance company for an explanation. If the insurance company finds an error was made, note the information and whom you talked with at the insurance company. Request an anticipated payment date and ask if they need anything to complete processing. Ask the rep for the reference # of the call. If the insurance company feels the bill was paid correctly and you still disagree, find out from the insurance company what you need to do to file an “appeal” with them. Filing an appeal will not guarantee that the insurance company will pay more on your bill, but the claim will be reviewed for reconsideration.