



Lexington
Clinic
Since 1920

PATIENT ACCOUNT PAYMENT POLICIES

May 2010 Update | Lexington Clinic Central Business Office

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Patient Account Payment Policies

Customer Service

Customer Service phone lines are open daily from 8:30a.m. to 4:30 p.m. You can reach a Customer Service Representative with questions regarding account balances by dialing locally within Lexington or with a toll-free number if you are outside of Lexington:

859.258.6000

800.565.6841, ask for Customer Service

A Patient Services Representative is also available on the first floor of both the Lexington Clinic East and South Broadway locations from 8:00 a.m. to 4:30 p.m.

Check-In

The registration process is essential to ensuring accurate claims submission to your insurance and promotes timely and appropriate payment of services. For proper registration, please arrive 15 minutes early. If this is your first visit to Lexington Clinic, please arrive 30 minutes prior to your scheduled appointment. Upon every visit with a Lexington Clinic provider, the check-in desk registrar will:

- Verify your address and telephone number
- Ask to see your most current insurance card(s)
- Collect any co-payment, co-insurance, deductible or other fee due at time of service
- Inform the doctor's office that you have arrived for your appointment and provide you with any necessary paperwork or directions

These basic steps are the most important steps you can take to avoid delays at check-in and are performed at each visit.

Registration Express Pass

If you become a frequent visitor to Lexington Clinic, or will have regular appointments for physical therapy, allergy injections, recurrent lab work, etc., please ask your registrar for a Registration Express Pass for faster check-in. An express pass is a free service and is valid for three months. This convenient service enables patients with frequent visits to experience quicker check-in by only requiring them to present a pass and any co-payment due when registering. Bearers of express passes are responsible for informing the registrar if there has been a change of address, status or insurance since the pass was issued.

Plan Participation, Network Requirements and Benefits

To verify our participation with your insurance plan, please contact your insurance carrier, your employer or our Customer Service Department prior to your appointment. Patients are strongly encouraged to verify their plan benefits and network requirements prior to their visit. This helps patients to avoid incurring unexpected financial responsibilities for the services they seek.

Pre-Authorization

Many insurance plans require prior authorization for hospital admissions and certain outpatient procedures or tests. In some instances, your physician may be aware of these requirements and will proceed with obtaining the proper authorization. However, it is impossible to know these requirements for all insurances on all procedures. It is important that you check with your insurance carrier to verify if your procedure or test requires authorization and let your physician know. Claims denied for lack of pre-authorization may be billed to the patient.

Medicare

Lexington Clinic is pleased to be a participating provider in the Medicare Program and will file claims for Medicare beneficiaries. Any deductibles, co-insurance or non-covered services are the responsibility of the patient. If there is supplemental coverage available, Lexington Clinic will file a claim to the second carrier as a courtesy. However, follow-up with the supplemental carrier, as well as amounts not paid, are the responsibility of the patient. Medicare does not always cover all services. There are certain types of routine care, as stated in the Medicare benefits, which may not be covered. Medicare patients should expect to be responsible for these services if they do not have other insurance coverage. There may also be some diagnostic tests that Medicare may not cover. This does not mean that these services are not an important part of the healthcare being provided to you. Your provider will notify you when it is suspected that tests may not be paid by Medicare and will result in an expense to you. Lexington Clinic does not participate in all Medicare Advantage Plans or Medicare Replacement Plans. Please contact our offices to verify if your Medicare Advantage Plan is accepted.

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Patient Account Payment Policies *continued*

Medicaid

Lexington Clinic offers limited acceptance of Kentucky Medicaid. However, out of state Medicaid is not accepted. If you are covered through the Kentucky Medicaid program, you are required to present your identification card at the time of service. Most of the departments within Lexington Clinic will accept your Medicaid card if you meet one or more of the following criteria:

- Covered by both Medicare and Medicaid
- The patient is a foster child
- An established patient of Lexington Clinic and seen within the past two years
- Referred by another physician within Lexington Clinic

Medicaid, other than Kenpac patients assigned to our primary care physicians, will not be accepted when the patient is self-referred or when the patient is covered under another insurance plan.

To verify if your Medicaid card will be accepted, please notify your doctor's office when scheduling your appointment or contact our Customer Service Department.

If you have applied for Medicaid and your application is approved after you have been seen, you may notify the Central Business Office upon receipt of your card. In some instances, but not all, we may be able to accept a backdated card. However, services not covered under the Medicaid program, or services not meeting the acceptance criteria for that department, as well as services provided without verification of pending coverage, will be billed to you.

HMO/PPO and Other Participating Plans

Lexington Clinic participates in a variety of HMO, PPO and commercial plans. In fact, we participate in over 10,000 plans. Due to the large number of plans, Lexington Clinic does not have the benefit details on each plan. It is important for patients to always check with their carrier or their benefits booklet before being seen to confirm the following information:

- Is the doctor or facility being seen covered by your plan?
- Is a referral or authorization necessary for the services to be covered?
- How much out-of-pocket expense will you owe for a visit to that provider?

At the time of your visit, you will be responsible for making any co-payment or other known out-of-pocket expenses. Lexington Clinic will file your claim and once processed, any additional amounts not covered by your plan will be billed to you. Payment will be due upon receipt of your statement. Examples of these amounts include additional co-payments mandated by your plan, deductibles, co-insurance or non-covered services as outlined by your policy.

Workers' Compensation

Lexington Clinic provides worker's compensation related services within several departments. When scheduling your appointment, please notify the receptionist that your visit is related to a work injury. In order to file your worker's compensation claim, we are required to obtain the following information:

- Employer – Name, address, phone number and an employer contact person
- Date of injury
- Claim identification number and/or employer authorization
- Name of worker's compensation insurance company
- Claim address and phone number
- Insurance Contact person

This information may be obtained at the time of your visit or by phone. Attempts will be made through your employer to verify authorization for your visit. If we are unable to verify authorization through your employer, you will be asked to present your group insurance information for filing. Patients seen for work related injuries who are unable to provide the required information, or for whom the employer has not provided us with authorization, may be asked to make payment for their services.

Motor Vehicle Accident Related Services

Lexington Clinic will submit a claim to your auto carrier when you provide the following information at the time of your visit:

- Date of accident
- Complete name and claim address of auto insurance
- Claim number

As a further courtesy, Lexington Clinic will allow up to 30 days for the auto carrier to make payment on your claim. At the end of the 30 days, you will be responsible for the unpaid balance. You are encouraged to remain in contact with your agent or the auto insurance carrier regarding the status of your claims, as well as the benefits of the plan, including any deductibles, policy limits or exclusions. If you are unable to provide the needed information for Lexington Clinic to file your claim, or if you wish to file the claim yourself, claim forms will be mailed to your home. In such cases, you will be required to make a partial deposit the day of the appointment. Unpaid amounts will be billed to you and will be due within 30 days.

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Patient Account Payment Policies *continued*

Other Accident Related Services

Services related to an accident, other than worker's compensation or motor vehicle, are the patient's financial responsibility. An example of this type of accident would be an injury sustained on someone else's property. You are required to make a partial deposit on the day of your appointment. Any amount incurred above the actual deposit paid will be billed to you and due in full upon receipt of your statement. Claim forms for your use in obtaining reimbursement will be mailed to your home. You will need to submit these to the appropriate insurance agent. You are encouraged to contact the insurance carrier or insurance agent in regards to the status of your claim and to inquire about the benefits available, including any limitations or exclusions that may affect the payment of your claim(s).

Other Insurance

You may carry a commercial group plan that does not fall into one of the other categories. As a service and courtesy to you, Lexington Clinic will file your initial claim on your behalf.

You may be asked upon arrival to make a payment towards your anticipated out-of-pocket amounts such as deductibles or co-insurance. Any amounts unpaid by you and your insurance after the claim has been processed, will be billed to you. You are encouraged to contact your insurance carrier prior to your visit to confirm your benefits.

Uninsured Patients

Lexington Clinic welcomes patients without insurance coverage. A deposit will be required on the day of the appointment. In most cases, this deposit serves as a partial payment only. The Central Business Office is available for price estimates. However, it is difficult to determine the total price for services yet to be provided. Only the physician can determine what services are necessary based on the nature of the presenting problem. Once evaluated, your physician may determine that labs, x-rays, injections or various other testing and/or procedures are necessary for treatment. The Central Business Office will not know how the physician plans to care for you until you have been seen. The partial payment that you pay on the day of the appointment serves as a deposit that will be applied to the total cost. Any additional amounts will be billed to you and are due within 30 days. A 20 percent discount will be offered to uninsured patients for payment in full on the date of service. This discount will not apply to prior balances or billed balances. For extended payment plans, please contact our Customer Service Department at 859.258.6000.

Financial Policies

We would like to take this opportunity to review the Lexington Clinic Financial Policy with you, our valued patient.

This information should help to answer many of the questions you may have in regards to billing and payment expectations. If there are any questions you have which are not answered, please contact our Customer Service Department at 859.258.6000 or 800.565.6841 ext. 6000.

Insurance Billing and Coverage

As a service to our patients, we will file eligible claims to all insurance carriers, unless prohibited specifically by your plan. Lexington Clinic is contracted with and accepts many local insurance plans, but not all. Prior to your service, you should always consult your insurance carrier or your benefit booklet for a list of providers and benefits available to you. This will allow you to verify the services and the provider you seek will be covered, identify any authorization requirements or exclusions, and also the level of benefit available. Many plans will provide some level of coverage to providers not listed in their network. Because coverage determinations are ultimately made by the insurance company, we are unable to guarantee their payment. Therefore, it is necessary that you be aware of the details of your coverage before obtaining care.

Insurance Follow-up

Lexington Clinic strives to always provide accurate and timely billing to insurance companies and to patients. In most cases, claims are filed and processed by the insurance company within 30 days. Any unpaid balances are billed to the patient within 30-45 days from the date of service. However, on occasion, a carrier may not respond immediately and further attempts to obtain payment from your insurance company may be required. In such instances, payment from the carrier may take longer than usual and you may be billed for amounts not covered by the plan at a later date.

Our offices generally make two or more attempts for payment from the group carrier. Occasionally, a claim may remain unpaid by insurance even after repeated efforts by our billing office to resolve it. In such cases, the unpaid balance may then be billed to you with an indication to contact your carrier regarding questions about the status of your claim. This is not our preferred method of billing. However, we have found that with the assistance of the patient in these instances, the claim is often resolved fairly quickly by the insurance. If not resolved by the insurance, then the claim will be due from the patient.

Referrals and Authorizations

Most plans clearly publish their referral and authorization requirements. Please ensure that your primary physician has forwarded a copy of your referral to our office, or bring a copy with you on your first appointment. You should also inform our office of any authorization requirements your plan has prior to your appointment. Usually this can be communicated at the time of appointment scheduling. Our office will then seek verification that your plan has authorized your treatment.

Account Balances and Payment Options

Co-payments and services not covered by insurance are due in full on the day of your appointment. Account balances, estimated deductibles and co-insurance amounts may also be requested when you check in, if this information was available prior to your appointment. Any amounts not covered by your plan, and not collected on the day of service, will be billed to you and are due in full upon the receipt of your statement. Patients will receive a billing statement each month for balances that are due from them. The bill is itemized and will reflect the cost of the service, how much the insurance has or has not paid, and the remaining balance for each service. Payment is due in full by the date indicated on the statement. The statement will also provide the total amount that is still considered pending with the insurance, but it will not be itemized nor will it be reflected in the amount due. Questions about this amount or an itemization can be obtained by contacting our Customer Service Department.

Partial Payment

Although payment in full is expected, partial payments can be arranged through our Customer Service Department. Monthly amounts are based upon the size of the balance. For your convenience, you can also select payment options offered through our website on account balances over \$150.00.

It is important that patients wishing to make partial payments either accept one of these offered options or contact our Customer Service Department to set up a monthly plan.

Payment Options

Account payments can be made at the time of registration, in person at one of our convenient locations, through the mail, over the phone or online by visiting www.LexingtonClinic.com, and selecting "Manage My Account."

Payment methods accepted:

- Check
- Cash
- Credit/Debit Cards – Visa, MasterCard, Discover, American Express
- Extended Payments Upon Approval

Delinquent Accounts

Accounts that remain unpaid after 60 days will be treated as delinquent and efforts will be made to collect unpaid balances. These efforts may include phone calls, letters and possible referral to an outside collection agency. It is our sincere desire to avoid outside collection agencies. As such, a notice will be mailed to the last known address on the account prior to any referral. Patients are strongly encouraged to work with our business office on suitable payment arrangements to avoid placement of their account with an outside agency.

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Financial Policies *continued*

Care Credit

Care Credit is a national credit card that can be used at participating medical and dental facilities. It allows individuals and families to manage their medical expenses on a single credit card. To apply for a Care Credit card, you can contact our offices for an application or log onto their website at www.carecredit.com

Manage My Account

You can now manage your account at a time that's convenient for you by accessing our secured website LexingtonClinic.com. This site allows you to view your most recent statement, make payments by credit card or electronic checking account debit, provide updates to your address, phone number or insurance information, and submit account questions to our billing office.

Frequently Asked Questions

How can I obtain my medical records?

Contact the Lexington Clinic Release of Information Department at 859.258.4837. Some records are maintained in Lexington Clinic's regional healthcare centers. In those situations, you may contact that physician's office directly and ask to speak to the staff member that oversees the release of information.

How do I find answers to billing questions?

Our knowledgeable team of Customer Service Representatives is happy to assist you with your billing questions. You may reach our Customer Service Department between the hours of 8:30 a.m. and 4:30 p.m. by calling locally 859.258.6000 or toll free 1.800.565.6841.

What is a "screening" or "routine" service, and why won't my insurance company pay for it?

"Routine" or "screening" services are provided in the absence of a disease, condition, or relevant symptoms. In other words, there is no medical condition that prompts performance of the service. For example, your physician may recommend that you have your cholesterol checked because you have a family member with high cholesterol. This would be considered a "screening" cholesterol test. However, if you have a cholesterol test performed because you have high cholesterol, this would not be considered a screening test.

These services are vital for early detection of many medical conditions. Some common examples include annual physicals, lab testing such as cholesterol; prostate, and occult blood testing; chest x-rays, EKGs, colonoscopy, flexible sigmoidoscopy, pap smear, mammogram, and digital rectal exam.

These services are very important for your care; however, this does not guarantee that your insurance company will cover them. If your insurance policy does not cover these types of services, you may become responsible for payment. We recommend you contact your insurance company to find out what type of "screening" coverage you have.

My insurance company told me if the claim had been billed differently then the service would have been covered. Why can't you change the way my claim was billed?

Medical billing is regulated and monitored by the government. The guidelines are very clear regarding how to properly code. A doctor must always accurately indicate the service or test performed as well as the precise reason it was performed. For instance, if you came in for an exam, your physician may perform several services or tests in order to diagnosis or monitor different medical conditions. This means that it is possible that not all of your services will have the same diagnosis (reason) code on the same day. This is very common during the course of a physical. Some services are routine in nature, while others may be ordered to follow-up on an established condition, such as hypertension. Because many plans have different benefits available depending upon the reason for the service, it is possible that they will pay differently on one or more services performed on the same day. Although it may be true that your insurance would have paid differently under a different diagnosis, a diagnosis cannot

be changed for the sole purpose of obtaining benefit coverage. The diagnosis must reflect the true reason the service was performed.

If you feel the diagnosis indicated on your claim is incorrect, our staff of experienced, certified coders will review your claim for accuracy and make changes as supported by the medical documentation.

Does Lexington Clinic accept my insurance?

Lexington Clinic is contracted with and accepts many local insurances. Please refer to your benefit or provider booklet for a list of doctors available to you and to verify your benefit coverage. Your plan may even provide a level of coverage for doctors not listed.

Why must I show my insurance card at every visit?

Insurance companies supply identification cards which are to be presented by the patient for all services. Insurance companies will sometimes update the cards with new information. Even though your coverage may not have changed, sometimes important filing data on the card has changed. The Business Office strives to submit claims on your behalf in both a timely and accurate manner. In order to avoid delayed payment and possible nonpayment of claims, verification of coverage is required each time you arrive.

Why am I receiving a statement from another laboratory that I have never been to?

Lexington Clinic has an independent lab to process tests ordered by both Lexington Clinic and outside physicians. However, as with many labs, there may be some tests that we are not equipped to handle internally. In such cases, the test may be forwarded to another lab for completion. Insurance information will be sent along with the specimen to assist with proper billing of your test.

I handle all the bills in my family; so why can't someone in the Business Office talk to me about my spouse's account?

Federal HIPAA laws set forth to protect the confidentiality of patient medical information prohibits Lexington Clinic from disclosing information without the consent of the adult patient. Detailed information can be discussed with a spouse once proper permission has been obtained. Please contact the Central Business Office to obtain an authorization form.

I have an H.S.A. (or H.R.A.) plan. Do I need to pay when I come in?

Health Savings Account (H.S.A.) and Healthcare Reimbursement Account (H.R.A.) plans generally have higher deductible and out-of-pocket costs. As with any deductible plan, you may be asked to make a pre-payment on services which are expected to apply towards your deductible. You can submit your receipt through your H.S.A./H.R.A. account for reimbursement of eligible expenses. Patients who have been issued H.S.A./H.R.A. debit cards, may be able to use these cards to access funds to cover these pre-payments at the time of payment.

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Frequently Asked Questions *continued*

I was seen recently. Why isn't my account coming up on the website?

The website provides you the ability to view your most recent statement and make payment on your balance due. If your account has not generated a monthly bill then the balance is not yet available for viewing. For information about your account balance prior to your scheduled billing date, please contact our Customer Service Department.

How quickly will my information be updated or my questions answered if I use the Manage My Account feature on your website?

Although the website itself will only update on each new statement cycle, the changes you submit will be made to your account within 1 to 2 business days. Questions about your account will be assigned to an account representative and responded to within 1-2 business days.

Please be sure to provide current contact information in your communication so that we can reach you.

Why isn't the payment I sent in showing on the website?

The website only shows payment history or pending payments for transactions that were submitted on-line. All other payments will be shown on your next statement. The website will provide you an updated statement once per month for as long as you have a balance due.

Why does the website reject my Care Credit card payment?

The website can be used for Visa, Mastercard, Discover or American Express credit transactions, as well as checking account payments. The Care Credit card requires a special terminal linked directly to that company. Payments made by Care Credit can be made at any of our cashiering locations or by calling our Customer Service Department.

Glossary of Insurance Terms

Allowable: The maximum amount the insurance company will allow on a specific service. For example, if your insurance plan pays 80-percent, then the payment will be 80-percent of the allowable that they have contracted, rather than 80-percent of the charge amount.

Ancillary Service: These are services such as lab tests, x-rays and other testing performed by technicians or other doctors at the request of your physician. Patients may not actually meet the physician in charge of interpreting their tests. These services are billed separately and in addition to your ordering physician's charge.

ASC: Ambulatory Surgery Center – This is a facility in which outpatient procedures may be performed. In addition to the surgeon's fee for the surgery, the ASC will also charge a fee for the facility.

Benefit: The amount paid by the insurance company towards specified services. Also known as the insurance plan payment, payment amount or paid to provider.

Charge: The total amount billed by your provider for the service rendered. Each service has its own charge amount which is the same regardless of the amount allowed by the insurance.

COB: Coordination of Benefits – When another insurance company has paid, the next insurance may lower their payment to coordinate with the first. This avoids overpayments of claims or patients making money from a visit to the doctor.

CPT Code: A code that describes the type of service that was performed by the physician. Also known as a procedure code.

Co-Insurance: A percentage of the total cost for a provider's service that the patient is responsible for paying as defined by their insurance plan benefits. Co-insurance does not include deductibles, co-payments, or non-covered expenses.

Co-payment: This is a specified amount, predetermined by the insurance company that the patient must pay at each visit. Most insurance plans require a co-payment for tests such as labs and x-rays. Co-payments are due at the time of service.

Deductible: The deductible is the minimum amount determined by the insurance plan that the patient is responsible for paying each year. Patients usually must meet their deductible before the insurance company will pay for services and is in addition to any co-insurance that may be required.

Deposit: A deposit is an amount that is required to be paid by a patient towards their services in advance. It is often a partial payment since it is impossible to always assess what services or tests will be required before the physician has seen the patient. Any amounts in excess of the deposit amount will be billed to the patient.

Disallowed: The amount above the allowed charge. This is the amount that is patient due for non-participating insurance plans and considered the adjustment/discount for participating insurance plans.

Discount: The amount that the provider and the insurance have agreed upon as the maximum allowed amount for the charge and for which the provider has agreed to lower the bill to meet. Discounts are also referred to as provider discounts, contractual adjustments or provider write-offs. When the insurance company and the doctor have a contract, these discounts are accepted. These are considered participating insurances.

EOB: Explanation of Benefits – The statement provided by the insurance company explaining what charges were processed, how they were processed, and how much was paid. Also described as a remittance, EOMB, explanation of medical benefit or explanation of payment.

HMO: Health Maintenance Organization – Insurance plans with strict usage guidelines. Care is coordinated within the network by the PCP, primary care provider. Non-emergency, out-of-network care is usually not covered. Specialist visits and tests usually require special authorization. Patients are required by their plan and their doctor to know their own benefits.

H.S.A./H.R.A.: Healthcare Savings Account or Healthcare Reimbursement Account – Funds are placed into these accounts by the employer and/or the employee to cover higher deductibles and co-insurances for covered expenses. Funds are available only up to the limit of available funds within the account and may not cover the entire deductible or other out-of-pocket expenses.

Medicare Replacements: Medicare replacement policies (also called Medicare HMO's, Medicare Advantage Plans and Medicare Private Fee-For-Service plans) are policies that cover Medicare eligible patients who have elected to withdraw from Medicare coverage in favor of a private plan with different benefits. These are not Medicare supplemental policies. Lexington Clinic will not accept or file claims for Medicare replacement plans. Patients presenting for care with such policies will be required to pay for services rendered.

Medicare Supplement: A plan which is purchased by the patient to specifically cover the co-insurance amounts not paid by Medicare. Many supplements will also pay the Medicare deductible and some plans will pay a few of the services not covered by Medicare. However, most services that Medicare does not cover are also not covered by the supplement.

Non-Covered Service: This is a term used by insurances to indicate a service is not eligible for benefits under your policy.

Non-Participating: An insurance company that does not have a contract with the provider. The patient owes all amounts not paid by the plan, including amounts considered to be not "allowed." Sometimes this is listed as non-covered or provider responsibility, but due to the lack of a contract, the patient is responsible for this amount as well.

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Glossary of Insurance Terms *continued*

Participating: When a provider has entered into a contractual arrangement with an insurance plan, they are said to “participate” with that plan. They may be referred to as a “network” or participating provider. This contract states the physician has agreed to accept the insurance company’s allowable and will lower the bill to meet that amount. Doctors do not participate in all plans. It is very important that patients know if their provider is in their network and participates with their insurance plan. Benefits may be paid differently for network providers compared to non-network. Generally, the patient owes less if they see a doctor that their plan has established as participating in their network.

Patient Due: The amount due from the patient for deductibles, co-insurance or non-covered services or non-participating disallowances. Also known as patient liability or member responsibility.

PCP: *Primary Care Provider* – The patient’s family doctor. When designated by an HMO type of insurance plan, this will be the only provider who can treat or refer the patient for tests or specialist care. Generally, PCP providers will practice in an Internal Medicine, Family Medicine, General Practice or Pediatrics department.

Pending: The term pending is used to describe services that have been billed to the insurance carrier, but the provider has not yet received a response or payment.

PIP: *Personal Injury Protection* – The benefit paid under your automobile insurance policy for your covered medical services due to an accident.

PPO: *Preferred Provider Organization* – A type of insurance plan that covers both network and non-network services. These plans usually encourage in-network visits by discounting these services. Patients will owe less if they see a network physician compared to a non-network physician. This type of plan may also have special authorization requirements for specific types of care. This plan and the provider require that the patient’s know and abide by these requirements in order to obtain maximum coverage.

Pre-Existing: This refers to a clause within many insurance policies that does not allow payment of claims for specific illnesses which were present prior to the effective date of the plan. Such a clause generally expires within 6-12 months after enrollment in the plan. This means that such services incurred after the clause has expired may later be covered. The patient will owe for any services denied as pre-existing.

Pre-Payment: A pre-payment is an amount, required from patients who have insurance, that will be applied towards estimated out of pocket expenses such as deductibles, co-insurance or non-covered services. Pre-payments are due at the time of service. Any amounts that are the patient’s responsibility in excess of the prepayment will be billed to the patient after the insurance has processed the claim(s).

Provider: Any doctor, healthcare professional or facility can commonly be referred to as a healthcare provider.

Specialist: A doctor or healthcare professional, other than a PCP, with an area of expertise outside of Pediatrics, Family Medicine or Internal Medicine.

Subscriber: The subscriber is the primary member or “holder” of an insurance plan. If the insurance is provided through an employer, the subscriber will be the enrolled employee.

UCR: *Usual and Customary Rate* – Also known as the allowable amount. This is the amount that the insurance has determined to be their maximum allowable for the charge. Generally, any amounts above the UCR is due from the patient as the provider has not agreed to accept the insurance’s fees.