Red Willow
COUNSELING & RECOVERY

Insurance 101

by Kathryn Johnson, Billing Specialist
billing@redwillowcounseling.com
435-890-3785

Dear Red Willow Client:

As a courtesy we will contact your insurance company to determine eligibility and benefit coverage for services with **Red Willow Counseling & Recovery**. However, it is important that you understand your benefit coverage and your responsibility for the cost of therapy.

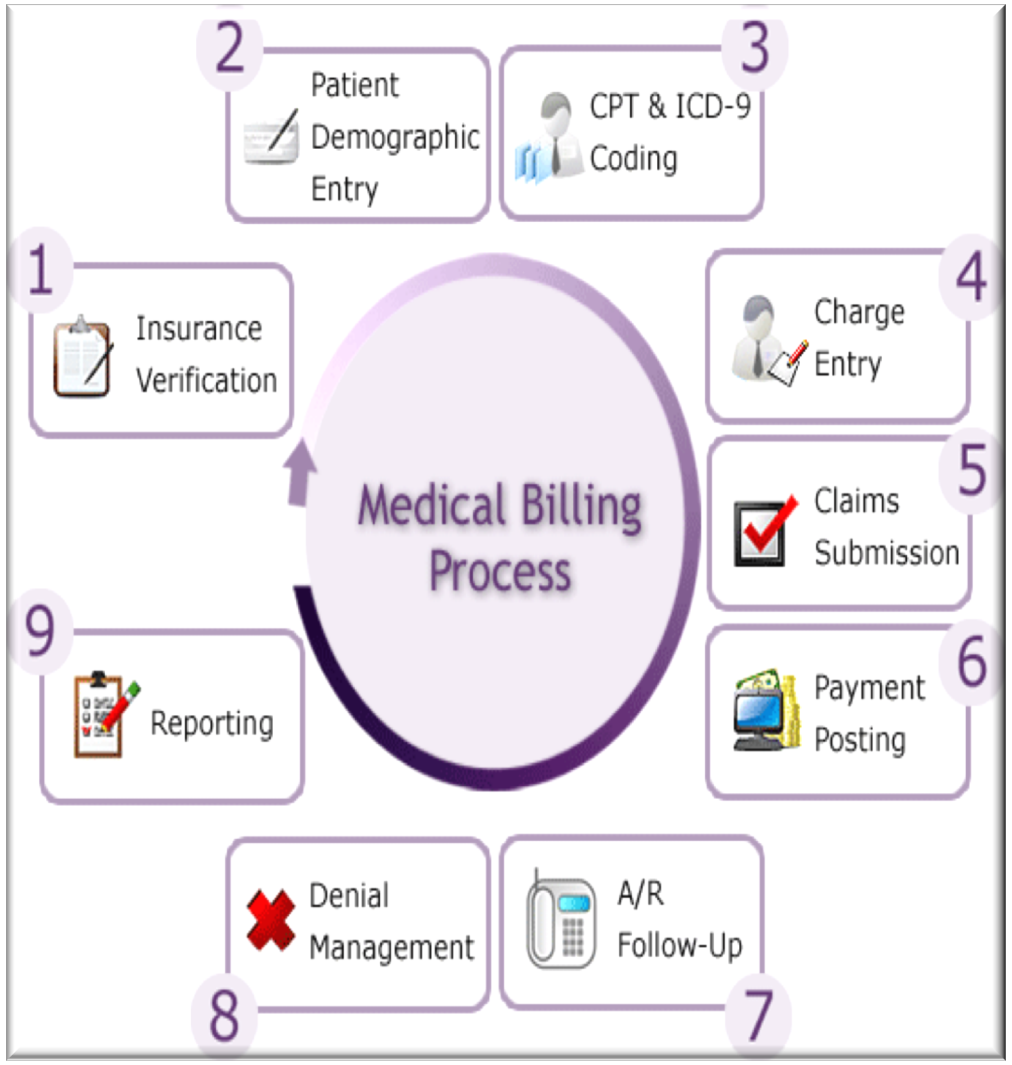
Please read the following information

1. Be Informed – You are your best advocate in knowing your insurance coverage and having insurance does not guarantee payment for services.
2. It is important for you to know your plan coverage for Mental Health prior to treatment.
3. If you have met your deductible, you will be required to pay the copay as determined by your insurance plan.
4. If you have not met your yearly deductible; claims will be submitted to your insurance company to be applied to your deductible, and you will be responsible for payment of services at the negotiated rate determined by your insurance company.
5. If your insurance is out-of-network, you will be responsible for payment at the time of service.
6. If your insurance company has an employee assistant program; you will be required to contact the EAP to request a referral and/or pre-authorization prior to being seen at your first appointment, and a copy of the letter must be received by the billing department prior to your first appointment.

If you have any questions, please contact me at the number listed below, or reach out to your insurance representative to clarify the information regarding your insurance coverage.

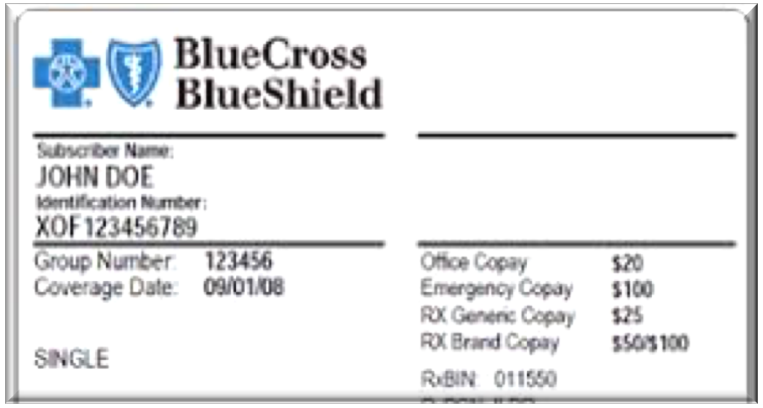
Kathryn Johnson

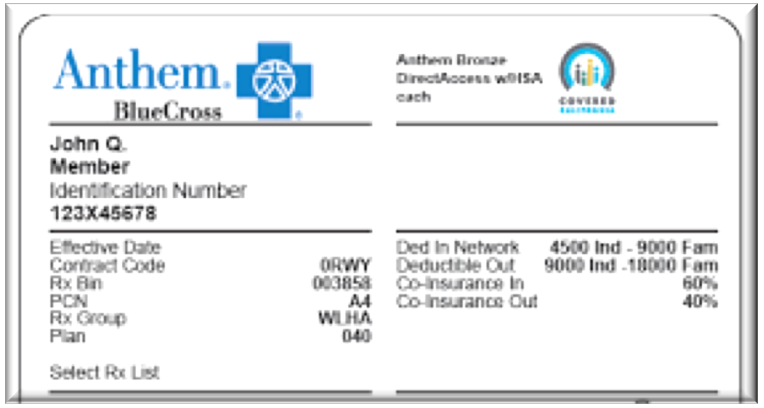
Billing Specialist

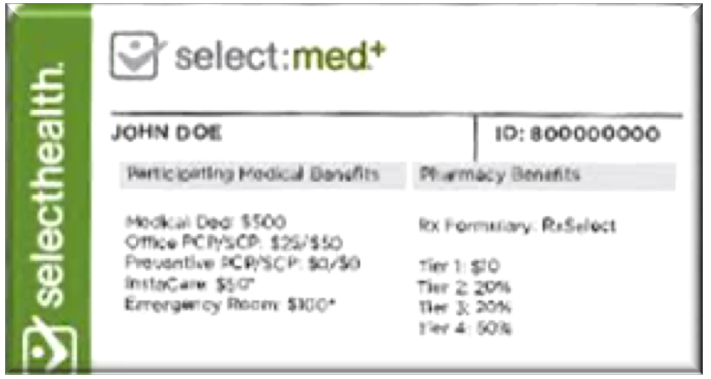


Steps taken for Each Client

1. **Insurance Verification** – A Benefit & Eligibility Check is essential in determining a client's copay and deductible amount efficiently.
2. **Patient Demographic Entry** – Documentation required for intake is essential for consent to treat, and if any information is missing this delays the process.
3. **Clinical Notes, Coding, and Diagnosis** – After a session is completed, the therapist completes specific notes to determine if the session is billable vs a non-billable therapy session.
4. **Charge Entry** – The insurance Billed Rate, the negotiated rate which determined by contractual agreement with in-network insurance, or Cash Rate.
5. **Claims Submission** – After completion of notes, claims are created and submitted electronically, or printed on specific form and mailed for processing by the insurance company.
6. **Payment Posting** – Allocation of payments received by insurance, client, etc.
7. **A/R Follow-Up - S**tatements, processing payments, arranging Payment Plans, Collections for non-payment.
8. **Denial Management** – If claims are rejected, insurance has terminated, processed incorrectly.
9. **Reporting –** Notification of balance due. Review of outstanding payments, reasons for non-payment by insurance, etc.
10. **Insurance Education** – I have added this one, as it continues to be an integral part of the billing process.







Sample Insurance Cards

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Jane pays 20% | Her plan pays 80%

(See page 6 for a detailed example.)

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

In-network Coinsurance

Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-network Coinsurance

Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment

A fixed amount (for example, $30) you pay for covered health care services from providers who do *not* contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

How You and Your Insurer Share Costs - Example

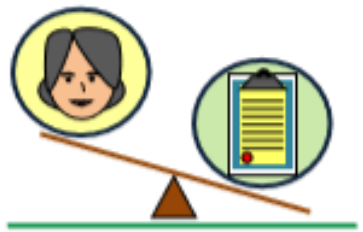
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

more costs

more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125