Insurance Billing Patient Handout

You are responsible for providing all insurance information and establishing the proper sequencing of primary and secondary coverage (coordination of benefits) at the time of registration. Copayments are due prior to the end of your dental visit/appointment.

All Access Dental will send a bill to your primary insurance company within a few days of your dental visit. Your insurance is expected to pay the claim within 30 days. After your visit, you should receive an Explanation of Benefits (EOB) from your insurance company, stating how much the insurance company paid and how much you owe.

You are responsible to verify that your insurance company pays in a timely manner. Fulfilling this responsibility may require you to contact your insurance company. Your coverage is between you and your insurance company. We will help you present your claim, but you must take ultimate responsibility for your account.

Most insurance plans have determined certain services that may not be covered, such as preventive visits, or elective services. We try to inform you of the rules ahead of time, but we don't always know if a service is covered. Since there are so many coverage plans available, you are encouraged to review your policy and contact your insurance company.

Here are some answers to the most frequently asked insurance billing questions for patients treated at All Access Dental:

- Will All Access Dental contact my insurance for precertification or authorization?

It is recommended you contact your insurance plan or provider directly if you have any questions or concerns about precertification or preauthorization.

- I have multiple health insurance companies. How do I know who to bill?

Coordination of benefit rules apply. Contact your provider to help in determining the proper order for billing.

- If my insurance doesn't consider All Access Dental as a preferred provider, will you bill my insurance?

All Access Dental bills all insurance carriers. If your insurance does not include an All Access Dental location as a preferred provider, you may be billed for non-covered charges or be responsible for reduced benefits.

Please contact your carrier to verify your coverage and/or benefits.

- What if my insurance company does not authorize or cover services?

You will be responsible for charges your insurance company does not authorize or cover. It is recommended that you contact our office to discuss whether to receive the service and for other possible financing options.

- Why aren't all services covered by my insurance company?

Under any plan, there may be services that are not covered because the insurance company may consider them routine or unnecessary. If you disagree with the decision, you should contact your insurance company for more information.

- What if my insurance coverage changes?

You should bring your current insurance card to your next visit. You should also contact our office to provide updated information.

- What should I do if my insurance sends its payment directly to me?

Insurance payments for claims sent directly to you, whether from primary or secondary insurance companies, should be used to pay outstanding charges to All Access Dental. Patients are financially responsible for all outstanding charges. Either deposit the insurance check and send us a personal check, or forward the insurance check as soon as possible.

- Why do I still owe a balance if my insurance company has been paid?

Based on your insurance plan, you may be responsible for deductibles, co-pays and co-insurance for fees not covered by your insurance company.

- What does usual and customary mean? How does this work?

The usual and customer fee schedule is set up so that non-contracted providers are reimbursed at a rate comparable to other HMO reimbursements in the same geographical area. The patient is responsible for charges that exceed the usual and customary rate.

- If I receive services because of an accident at work, will you send the claim to my employer?

Due to confidentiality, we are unable to send bills directly to your employer. However, we will send claims directly to your employer's Workers Comp carrier. We will need the name, address and claim number. You may take your bill to your employer and work directly with them and be reimbursed for the services you received by us. You are ultimately financially responsible for the services.

- What is the difference between an HMO and PPO?

HMO stands for Health Maintenance Organization. An HMO is a group that contracts with medical facilities, physicians, employers and occasionally individual patients to provide medical care to a group of individuals.

PPO stands for Preferred Provider Organization. As a rule, you must select a primary care physician (PCP) who is under contract with the PPO. If you choose a doctor not under contract, you pay more. Like an HMO, you usually pay a small amount known as a copay each time you visit your PCP or health-care facility. Unlike an HMO, if you choose to see a doctor who is not contracted with the PPO, the plan might pay a percentage of the medical bills (out-of-network benefits). However, your cost will probably be higher than if you choose a caregiver that is in the plan's network.

- Why did my insurance only pay part of my bill?

Most insurance plans require you to pay a deductible and/or co-insurance. In addition, you could be responsible for non-covered services. Please contact your insurance company for specific answers to your questions. You may have out-of-pocket expenses.

- What is a co-payment?

A copayment is a set fee the member pays to providers at the time services are provided. Copays are applied to emergency room visits, hospital admissions, office medical and dental visits, etc. The cost is usually minimal. The patient should be aware of the copayment amounts prior to services being rendered.

- What is a deductible?

Deductibles are provisions that require the member to accumulate a specific amount of medical bills before benefits are provided. For example, if a member's policy contains a $500 deductible, the member must accumulate and pay $500 out of pocket before the insurance carrier will pay benefits. Once the patient has met their deductible, the carrier usually pays a percentage of the bill. The patient is liable for the unpaid percentage. Deductibles are yearly, usually starting in January.

- What is co-insurance?

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

- If I have an HMO policy, can I be billed if they do not pay?

If you have an HMO policy, you should only be billed for the amount specified on your Explanation of Benefits (EOB) that is provided to you by your insurance carrier. This usually includes copay amounts.

- Is my insurance in network?

Please contact your carrier to verify your coverage and/or benefits.