Insurance 101

COMMON PHRASES AND DEFINITIONS

Claim - When your care provider bills your insurance company for services rendered. For example, your orthopedic surgeon bills insurance company A for $250.00 and they will pay only $125 of that claim. That leaves the remaining balance of $125 to be paid by the policyholder.

Explanation of Benefits (EOB) - This is an itemized statement of when you've seen a healthcare professional, and they bill your insurance provider for services rendered. It usually arrives at your home/email 30 days after the service is billed to the company.

Appeals - If your health insurer refuses to pay a claim or ends your coverage, you have the right to appeal the decision and have it reviewed by a third party. You can ask that your insurance company reconsider its decision. Insurers must tell you why they've denied your claim or ended your coverage. This process is commonly called an Admin reconsideration and is usually completed within 30-60 days depending on who your provider is currently.

HMO vs PPO - The biggest differences between an HMO and a PPO plan are:

Patients with an HMO must always first see their primary care physician (PCP). If your PCP can't treat the problem, they will refer you to an in-network specialist. With a PPO plan, you can see a specialist without a referral. (However, there are exceptions for emergencies or routine-care, in-network visits to a gynecologist or obstetrician).

With an HMO plan, you must stay within your network of providers to receive coverage. Under a PPO plan, patients still have a network of providers, but they aren't restricted to seeing just those physicians. You have the freedom to visit any healthcare provider you wish.

So, what's the catch?
Well, staying in your network with an HMO, you can expect the maximum insurance coverage for the services you receive according to your plan. Go outside of your network and your coverage disappears. With a PPO, you can visit doctors outside of your network and still get some coverage, but not as much as you would if you remained in your network.

Appeal Checklist

Below is a list of forms and documents that may be required
for you to appeal an insurance claim denied by insurers.

Please note: Patients and insurers vary quite a bit and may need different information filled out.
Please review your insurance company's denial guidelines to determine what to include.

TIPS

1. Insurer denial should have a reason. Insurers send out a letter of denial or include it in an EOB. Make your appeal specific to the reasons why your claim was denied.
2. Involve your healthcare providers. Many denial letters include a number for your healthcare team to call on your behalf.
3. Insurers should respond within 30-60 days of the appeal process submission. If they do not, reach out and check on the status.
4. Keep a copy of all insurer documents until the appeal is resolved.

WHAT TO INCLUDE IN YOUR APPEAL:

- ☐ Statement of medical necessity by healthcare provider
- ☐ Patient authorization or release of information forms
- ☐ Appeal Letter
  - Introduce yourself, include claim number
  - Explain situation
  - Include why denial was wrong
  - Explain how appeal would change outcome

- ☐ Denial information or EOBs
- ☐ Copy of your health coverage plan
- ☐ Supporting documents
  - Health history, such as diagnosis, pathology, and findings
  - Healthcare provider's notes
  - List of treatments tried without success
  - List of medications
  - Scientific literature supporting your treatment plan that was denied