Insurance Verifications

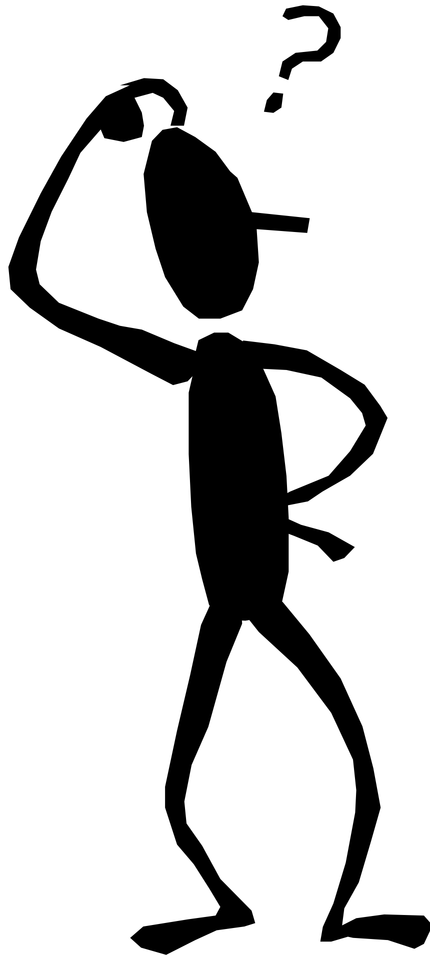
One Key to a Successful Office

CB&C, Inc.

Properly done Health Insurance Verifications can:

- Be the key to obtaining the maximum reimbursement from both the patient and the insurance carrier
- Streamline:
  - the patient billing
  - the insurance billing
  - receipt of payment
- Minimize time spent on follow-up
- Assist in retaining patient in your office at all

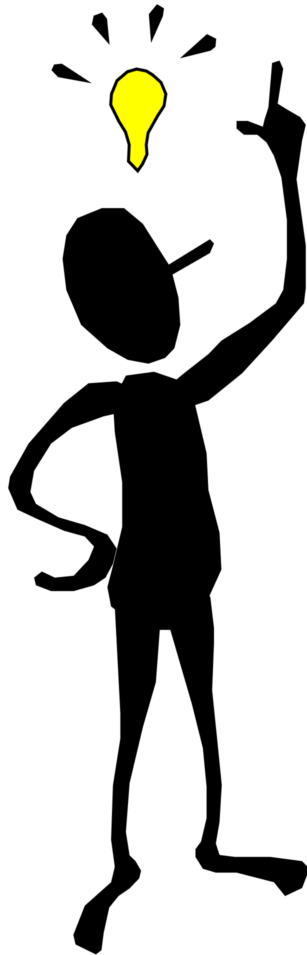
Health Insurance Verifications



When consulting for chiropractic offices we find that questions asked in the verification process are often pretty basic. Why waste this opportunity?

CB&C, Inc.

Health Insurance Verifications



It’s worth saying again - a properly done verification can streamline the patient billing, the insurance billing, receipt of payment, and minimize time spent on follow-up

Questions that offices routinely DO ask in the verification process:

- The patient's benefits (deductible, coinsurance, copay)
- The chiropractic / therapy limit
- The effective date of the policy

Questions that some offices may also ask:

(these are slightly ahead of the first group)

- How many services are covered per day?
- WHAT services are covered?
- What is the claim submission address?

Questions that most offices DO NOT ask:

- ***Is the policy running on ‘benefit year’ or ‘calendar year’?***
- ***Is the policy self-funded (the carrier is really only functioning as a TPA) or is the policy fully insured***?
- ***Is COB updated?***
- ***Will chiropractic claims be pended for accident information***?
- ***What is the in network coverage vs. the out of network coverage?***
- ***If out of network – is the policy paying at R&C?***
- ***If in network – at what fee schedule will this claim be paid?***
- ***Is there a pre-existing clause that may delay payment?***

Additional Verification Tips

- Besides the rep’s name and the date - get specific reference numbers for your calls
- Consider recording your calls
- Create your own ‘chiropractic reference sheet’
- Consider having a ‘verification service’
- Offices often use the same form for all types of verifications - consider creating one for Health, one for PIP, one for Medicare with secondary, etc.

Examples of Forms

- Health Insurance Verification Form
- COB Form
- Statement of Non-Accident

INSURANCE VERIFICATION
HEALTH INSURANCE

PERSONAL INFORMATION:

Name:_______________________________________ SS#________________ DOB:_____________ Male / Female

Address: ____ Phone: (H)_____________ (Other)___________

Diagnosis:____

PRIMARY INSURANCE:

Insurance Carrier: ______________________________

Send Claims To:______________________________

____

Phone # ______________________________________

Electronic Payor ID#: ___________________________

Effective Date____________________________________

Benefit Period: ____________________________________

ID#______________________GP#________________

Policy - SP, PC, HW or FP? Employer________________

Insured:____________DOB:________Relation:_______

Other family members:____________________________

Is this a self funded plan - therefore you are a TPA?_______

☐ ***Out of Network Coverage***:

Individual Deductible $________ Amt Met $_________

Family Deductible $__________ Amt Met $__________

Deductible Carryover(if applicable)_________________

Coinsurance: Ins_______ Pt _______ OOP ________

Will this be paying at R&C? ______________________

Required? LMN _____ Precert ___________________

Limted # of visits ________ / dollar cap __________

Limit is: per year / per diagnosis / per day

☐ ***In Network Coverage:***

Deductible $_________ (Amt Met _____) Coins: ______

OR Copay $___________________

Required? PCP referral __________________________

Precert ________________________________

Limited # of visits ___________ / dollar cap ___________

Limit is: per year / per diagnosis / per day

Managed Care Network / Fee Schedule_________________

Have any chiropractic benefits been used this year whether in or out of network? ____

Covered?Xrays Y / N--95831, 95851 Y / N--Exams Y / N---Supports, pillows Y / N---Foot Levelers L3020 Y / N---Training 97760 Y / N

How many modalities are covered when billed with CMT code?:________ Which modalities: 97124 / 97110 / 97140 / 97112 / 97139 97530 / 97012 / 97010 / 97014 / G0281 / G0283 / 97535 / 97035 / 97022 Is 98943 covered if billed with 98940 - 98942 ________?

Can a chiro refer for an MRI?________ Does it need Precert?________________________ Special Facility? _________________

*** If there are no 'chiro benefits' will you cover other services (PT, Exams, Xrays, etc) when performed by Chiro _______________

Will you be requesting accident information if patient is being seen by DC?____

Has COB/LOI been handled for the current year (if applicable)?____

CMS 1500 or special claim form?________________ Any pre-existing condition clause?_________________ Expires?_________

Can payment be sent to the provider if there is a valid assignment of benefits?____

What is your timely filing? _____________________ If secondary to auto carrier, is there a subrogation clause?___________

Name & Call Ctr of Rep: _________________________ Ref# ______________ Date:________ Time: _____ Office Rep ______

This form has been created by and is the sole property of CB&C, Inc. (973)827-3544

Example

Date: ________________

Dear Insurance Carrier,

I understand you may be holding up payment of my claims because you are waiting to update your records regarding my status and my coverage. The following is my updated information:

Name of patient ____________________________ SS# _________________ DOB ____________

Insured Information:
Insured Name___________________ Policy ID#______________ Relation to Insured__________

PLEASE CHOOSE SECTION THAT APPLIES & CHECK ONLY 1 LINE

Spouse / Partner:

_____ I am the patient AND the insured AND I have no other insurance coverage

_____ I am the patient, BUT the insured is my spouse/partner _______________. I am not employed and therefore have no other insurance coverage of my own.

_____ I am the patient, BUT the insured is my spouse/partner ________________________. I am employed at ____________________ but have no coverage through that employer.

_____ I am the patient & have my own coverage - the following is my coverage information:
Primary Ins ____________________ Insured Name: _________ Insured DOB: ______
Secondary Ins ___________________ Insured Name: _________ Insured DOB:______

___________________________ _________________
Signature Date

Dependent Child Over 18: (covered under parent's policy)

_____ I am a FT student & have 1 policy. Attached is my current school schedule.
Primary Ins ____________________ Insured Name: _________ Insured DOB: ______

_____ I am a FT student & have 2 polices. Attached is my current school schedule.
Primary Ins ____________________ Insured Name: _________ Insured DOB: ______
Secondary Ins ___________________ Insured Name: _________ Insured DOB:______
**determining primary/secondary is usually based on the 'birthday rule'.

___________________________ _________________
Signature Date

Dependent Child Under 18: (covered under parent's policy)

_____ I am a minor dependent and only covered under one policy :
Primary Ins ____________________ Insured Name: _________ Insured DOB: ______

_____ I am a minor dependent and covered under two policies :
Primary Ins ____________________ Insured Name: _________ Insured DOB: ______
Secondary Ins ___________________ Insured Name: _________ Insured DOB:______
**determining primary/secondary is usually based on the 'birthday rule'.

___________________________ _________________
Parent or Guardian Signature Date

Example

Revised 10/25/08
This form was created by and is the sole property of CB&C, Inc. (973)827-3544

Date: __________

Dear Insurance Carrier:

I, ______ ________________________, am currently receiving chiropractic care at __________________________________this facility. Please know that this care is ***not related*** to any auto accident, workers' compensation injury or any other type of injury, which would render a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact me personally.

____
Print Name

_________________________ _____________
Signature Date

Example

Revised 10/25/08 – CB&C Use
This form has been created by and is the sole property of CB&C, Inc. (973)827-3544

Our Contact Information

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- Full Service Billing & Collections
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