SAINT CLAIR ALLERGY AND ASTHMA CENTER, PLLC

PATIENT INSURANCE VERIFICATION INFORMATION SHEET

Hello! Thank you so much for allowing us to care for you! We understand that insurance coverage can be very confusing and frustrating to navigate. This is a guide to assist you in your insurance verification process.

Our office asks that our patients verify their insurance benefit coverage before every appointment. Why is this? Very simple – all health insurance policies are different. There are literally thousands of plans just with Blue Cross Blue Shield and no two plans are ever the same. While we try our very hardest to verify your benefits as a courtesy to you - it is very important for you to know your own insurance benefits to plan for any out-of-pocket costs. Many insurance plans are updated and/or changed at the beginning of a benefit period. This can mean that a service that was performed and covered on 12/01/2021 may not be covered on 1/15/2022 because an employer has dropped the service from your coverage plan. If you have a deductible – this deductible may apply to a service this year but it may not have applied to that same service last year. Also, deductibles reset at the beginning of a benefit period. This is usually on the first day of every new year.

It is ultimately your responsibility to know what your insurance contract covers. *Insurance contracts are between the consumer and the insurance company. We do not carry any special privileges with insurance companies. In fact, it is quite the opposite! You are your best advocate!*

While we do try to verify every patient's insurance coverage, we are only given very general information because we are a third party. Privacy laws and regulations also apply to us even if you are our patient. Sometimes we are given incorrect benefit information. We have found that it is best to have our patients verify their benefits along with us and prior to their appointments.

FIRST LET'S TALK HEALTH INSURANCE JARGON!

For some patients, insurance plan lingo can be as clear as mud! What are the most useful terms and what are they?

Deductible – the amount that a patient must pay out of pocket FIRST before insurance will reimburse a provider. We do not receive any payments from your insurance company until you have met your deductible. The deductible amount is given to us to collect from you from your insurance company for the service that we performed. If you do not pay the deductible, we are not paid. We are also bound by our provider contract and must collect all patient responsibility charges that your insurance says you must pay. We cannot "write off" this charge. Doing so breaches our provider contract. This may lead to an insurance company revoking our contract for any patients with the same health insurance provider.

Copay – an out-of-pocket cost separate from your deductible that applies to the out-of-pocket maximum. Copays usually continue after the deductible has been reached. For example, your health insurance plan states that you have a $25 copay for a specialist visit. Your out-of-pocket maximum is $4000. You will pay $25 per specialist visit until you have paid $4000.

Coinsurance – your share of the costs of your health care services. This is usually a percentage of the total amount reimbursed to a provider from your insurance company. This amount is most times also applied to your out-of-pocket maximum. You may have to pay a copay and a coinsurance until that out-of-pocket maximum has been reached.

Out of Pocket Maximum – the maximum amount that you are expected to pay in a given benefit year. This is usually separate from the deductible. It all depends on your insurance contract. For example; You could have a contracted $3500 deductible and a $4000 out of pocket maximum. The deductible will have to be reached before your insurance company pays for any service. Once the deductible is reached, your copay and coinsurance will then start and apply to the out-of-pocket maximum.

Allowed amount – the amount that your insurance company will pay for a service. No matter how much a provider or facility charges your insurance company, the insurance company has a set amount that it will pay per our provider contract (fee schedule). You will not pay above that amount unless, of course, the service is not covered by your benefit plan.

CPT Billing Code – the unique numerical code used for billing and reimbursement.

How to Receive Insurance Benefit Information by Phone:

1) Call the member services number on the back of your insurance card.
2) Choose the option to obtain benefit and eligibility for medical services. The best option is to speak to a representative.
3) Ask if our office is in network with your insurance company. We are in network with most insurances. We are not in network with Medicaid or Marketplace acquired Priority Health HMO, Total Health HMO and United Healthcare Community Plan (Medicaid). There are new insurance plans that pop up every year and we may not have a contract. Therefore, your insurance company will not pay for your services.
4) The representative may ask you for the following:
    - Office Name: Saint Clair Allergy and Asthma Center PLLC
    - Provider: Dr. Anne White
    - NPI: 1003815234
    - Address: 25200 Little Mack Ave. St. Clair Shores, MI 48081
5) Next, ask if the following CPT billing codes are a covered benefit for your insurance plan. Please also ask if the CPT billing codes apply to your deductible. While the insurance company says that a service is covered, many patients are taken aback when they receive an invoice for the service because the service applied to the deductible. This does not mean that the service is not covered because it is covered. You just haven't reached your deductible for the year.

If you are a new patient:

- 99204 – New patient office visit
- 95004 – Allergy testing (scratch testing)
- 95024 – Intradermal allergy testing
- 94375 – Spirometry

If you are an established patient:

- 99214 – Follow up office visit
- 94375 – Spirometry (for asthma patients and any patient experiencing shortness of breath or difficulty breathing)
- 95004 – Allergy scratch testing
- 95024 – Intradermal allergy testing

If you are thinking about allergy immunotherapy:

- 95165 – Allergy immunotherapy extract
- 95117 – Dual allergy injections
- 95115 – single allergy injection

Special Testing CPT codes:

- 95076 – Oral Challenge
- 95044 – Patch Testing
- 95018 – Drug allergy scratch testing

6) Finally, ask if a referral is required to see a specialist. *All Blue Care Network patients MUST have a global referral from their primary care physicians before being seen by our providers. The global referral must include the date of the appointment. It is also your responsibility to keep track of your global referral and any need for continuation of the global referral. Typically, we require Blue Care Network patients to reschedule an appointment until a global referral is received.*

7) **Last and very important – Always ask for the representative's name and a call reference number!** Log each time you speak to a representative, the time and date, the name of the rep and the answer that they gave you to your question. This comes in handy if you were told incorrect information and can save you from expensive bills!

You can also check your benefits online:

1) Go to your member services website and log in. You may have to create an account if you have not already done so.
2) Find your benefit and eligibility information page.
3) The terms you will need to find are: "allergy office visits", "allergy testing", "allergy therapy" and "allergy injections". *Most auto company Blue Cross Blue Shield plans do not cover allergy testing or allergy injections.*
4) If in doubt, always call your insurance company and speak to a representative referencing the insurance verification phone call instructions above!

We thank you again for your trust in your care! If you have any other questions regarding your health insurance benefits, please contact the health plan directly or your health plan administrator.