**Authorization and Time of Service overview**

**Authorizations overview**

Denied claims due to unauthorized patient procedures or services can be a major loss in revenue that should not be taken lightly. Although most medical offices are moving closer to 100% verification for patient services, there is still no guarantee that every account will make it through the insurance company claims department stamped paid.

Claims that deny due to no prior authorization happen primarily in a hospital setting. Although the procedure may take place in the hospital, the responsibility lies with the physician’s office to obtain the prior authorization. REFERRING PHYSICIANS OFFICE SHOULD GET AUTH for all HMO’s and most of their patients.

Of course it makes sense for the physician to be responsible for obtaining authorization because they are ordering the procedure as part of the treatment for their patient. The physician has the patient's medical history and all information that the insurance company wants to make their determination. However, the medical office is ultimately responsible to insure that the authorization is obtained because the hospital will lose revenue, not the physician.

It only takes a little extra effort on the part of the medical office to guarantee that the necessary steps have been taken to avoid lost revenue for no prior authorization. Follow these simple steps.

1. As soon as the patient has been scheduled for a procedure, the [insurance verification](http://medicaloffice.about.com/od/insuranceverification/tp/Insurance-Verification.htm) process should begin.
2. If the insurance company requires authorization for the procedure, contact the physician’s office immediately to find out if authorization has been obtained.
3. If the physician's office has obtained authorization, get the authorization number from them. If they don't have it, contact the appropriate department at the insurance company to get the authorization number. It is also a good idea to make sure the information they have matches your records.
4. If the physician's office has not obtained authorization, politely inform them that they must get it before their patient can have their procedure. Usually physicians are very compliant with this request. They want their patient's to have the best care and would not do anything to jeopardize them from being able to have a procedure performed.
5. Always follow-up with the insurance company. If possible request a fax of the approved authorization for your records. You may need it later.
6. If a procedure changes or something is added at the last minute, contact the insurance company as soon as possible to add the changes to the authorization. Some insurance companies allow as little as 24 hour notice for approval on changes.

The basic idea here is to check, and then check again and when you're done checking, check one last time. Never assume that the physician office has obtained an authorization. Also, never assume that pre-authorization isn't required. Each insurance company including Medicare and Medicaid have their own guidelines and what is not required for one may be required for another.

**How do deductibles, coinsurance and copays work?**

When both you and your health insurance company pay part of your medical expense, it’s called cost sharing. Deductibles, coinsurance and copays are all examples.

Understanding more about what the words deductibles, coinsurance and copay mean—and how they work together—will help you make the right choice when you’re selecting a health insurance plan.

**Understanding the terms**

Deductibles, coinsurance and copays are all amounts you may have to pay for health care services. Here’s how they work together.

**Deductible-** A deductible is the amount you pay for health care services before your health insurance begins to pay.

For example, if your deductible is $1,500, you would pay 100 percent of your health care charges until the amount you paid reaches $1,500. After that, some services you receive may be covered at 100 percent, or you may have to pay coinsurance.

These are some other words you may see.

After deductible: This lets you know that we start sharing costs with you for a service after you’ve met your deductible.

No deductible: You don’t have to pay toward your deductible for this service. You’ll still have to pay any copays.

Before deductible: We cover this service before you’ve met your deductible. You’ll still have to pay any copays.

**Coinsurance-** Coinsurance is your share of the costs of a health care service. It's usually figured as a percentage of the total charge for the service. You start paying coinsurance after you've paid your plan's deductible.

Say you’ve already paid out (or met) your $1,500 deductible and your coinsurance is 20 percent. For a $100 health care bill, you would pay $20 and your insurance company would pay $80.

**Copay -** Acopayis a fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service. You may also have a copay when you get a prescription filled.

For example, a doctor’s office visit might have a copay of $30. The copay for an emergency room visit will usually cost more, such as $150. However, there is a maximum amount you will pay for [coinsurance and copays](http://www.bcbsm.com/index/health-insurance-help/faqs/topics/how-health-insurance-works/out-of-pocket-maximums.html). This is called the coinsurance and copay maximum.

**How to Verify Benefits & Eligibility for Health Insurance**



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Insurance companies verify benefits and eligibility to members and providers.

Members call insurance companies before seeing a physician to make sure their services will be covered. Is the provider participating with the health plan? What benefits are available to them? Providers also call insurance companies to determine whether a patient is covered. Health insurance companies will ask many questions before they release information about a patient, because they are required to do so by HIPAA (the Health Information Portability and Accountability Act of 1996.

**Instructions**

* + **1** Gather information. Have a copy of the member ID card ready. If you are a provider, you will need your tax ID or NPI number. You will also need personal health information (name, date of birth, etc.) before the insurance company will confirm benefits or eligibility.
	+ **2** Call the insurance company. Contact information for providers and members is listed on the back of the member ID card.
	+ **3** Specify the reason for the call. Are you a member or provider? Are you determining benefits or checking eligibility?
	+ **4** Confirm personal health information about the patient. They will ask for the member's name, date of birth and policy number. In order for the insurance company to release information, your answers to their questions must match their records.
	+ **5** Verify eligibility. This is the time to ask the representative if a patient is covered. What day did coverage become effective? Has the policy terminated? Were there any breaks in coverage for the patient?
	+ **6** Verify benefits. Ask the representative if a specific procedure or medication is covered. Does this plan have routine-care benefits? Are prior authorizations for a procedure needed?
* If you are a provider, check with the insurance plan if benefits and eligibility can be verified online. Some insurance companies may require more or less personal health information about a patient before they will release information.