

**INGENIX®**

# **Insurance Directory**

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**2008**

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# Claims Processing

The term “claims processing” describes the course of submitting a claim to the payer and subsequent adjudication by the payer. Understanding how this process works allows providers and staff members to file claims properly and leads to maximum and timely reimbursement. In addition, this knowledge will allow you and your staff to serve as a resource to patients in understanding this process.

## PATIENT INFORMATION

Before filing any claim, you need to obtain clear, accurate information from your patients. A good patient information (PI) form is the key to this aspect of claims submission. The PI form should include such basic items as the policy name and number, insured’s name, dates of coverage, and secondary insurance information. While this information is a good place to start, it is by no means all of the information required by most insurers. Providing as much information as possible will reduce the insurance company’s need to contact your office. Avoiding unnecessary contact will reduce the costs of claims processing and hasten your payment.

You may also wish to preregister new patients over the phone or, if time permits, through the mail. Having a shortened version of your PI form for phone registrations could be valuable.

Patient information must be updated regularly. Most offices verify the information at each visit. If you work in a multiple physicians’ office or clinic, establishing a uniform information policy makes everyone accountable for current and correct patient data.

Patient information forms follow the same basic pattern, but each differs by the type of patient your office might encounter. Each form is titled with the targeted group’s name. If your office has some special information needs or you wish to include additional instructions, consider using the back of the form. If your practice has a high volume of Medicare patients, you may want to consider two separate forms—one for Medicare patients and another for non-Medicare patients. These forms could be printed on different colored paper for easy identification.

### Primary vs. Secondary Coverage

Households with dual incomes often have more than one insurer. You must determine which is the primary and which is the secondary insurance company. For commercial plans, the

subscriber’s or insured’s insurance company is always primary for the subscriber. In other words, the husband’s insurance company is primary for him and the wife’s insurance company is primary for her. However, the primary insurance company for any dependents is determined by the insureds’ birthdays, the primary insured being the individual whose birthday is first during the year. This is often referred to as the “birthday rule.” For example, if the husband’s birthday is October 15, 1965 and the wife’s birthday is March 1, 1967, the wife is primary for their dependents because her birthday is first during the year (year of birth is ignored). Therefore, obtaining a date of birth for both subscribers is important.

### Assignment of Benefits and Release of Information

If you haven’t already done so, consider adding an assignment of benefits statement to your patient information form. It should state that the patient has agreed to have insurance payments sent directly to the physician and that medical information can be released to the patient’s insurance company. A signed copy of this assignment submitted with a claim helps ensure at least partial payment from most commercial insurers. Assignments also reduce collection expenses. An alternative, lifetime assignment of benefits, should nearly eliminate the need to obtain a signature after each date of service; however, there are a few payers who require a current signature with each claim.

If your office participates with Medicare, remember that an assignment of benefits and a release of billing are still necessary. To avoid the hassle of obtaining updated signatures, you may want to obtain lifetime assignment agreements and a commercial insurer’s yearly signature agreement. Most commercial payers accept the yearly signature agreement form, but it is not applicable to the Medicare patient.

### Determining Coverage

Ideally, a patient’s insurance coverage should be verified before any nonemergent service is rendered. This policy shouldn’t apply exclusively to new patients. Established patients may have changed employers, gotten married or divorced, or may no longer be covered by the policy that was in effect during their last visit.

When a new patient appointment is made, stress that the patient must present a current insurance identification card. However, a copy of the card does not guarantee eligibility. You may want to take the pertinent information over the phone to verify benefits before the patient arrives. Many payers now allow

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