PATIENT GLOSSARY OF HEALTHCARE BILLING TERMS

A

Account Number- Number you're given by your doctor or hospital for a medical visit.
Actual Charge- The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount an insurance plan approves.
Adjustment- The portion of your bill that your doctor or hospital has agreed not to charge you.
Advance Beneficiary Notice (ABN)- A notice the hospital or doctor gives you before you're treated, telling you that Medicare will not pay for some treatment or services. The notice is given to you so that you may decide whether to have the treatment and how to pay for it.
Allowed Amount- The maximum amount the insurance company will use when deciding what to pay for a covered health care service. This is sometimes referred to as "payment allowance" or "negotiated rate." It is also the basis for calculating your coinsurance, which is a percentage of the allowed amount you are responsible for paying. The allowed amount will be described in your policy or certificate of coverage. It may be based on a fee schedule, a database, or a percentage of what Medicare pays. You may have to pay the difference if your provider charges more than the allowed amount and the provider is not an "in-network" provider.
Amount Not Covered- What your insurance company does not pay. It includes deductibles, co- insurances, and charges for non-covered services.
Amount Payable by Plan- How much your insurer pays for your treatment, minus any deductibles, coinsurance, or charges for non-covered services.
Appeal- A process by which you, your doctor, or your hospital can object to your health plan when you disagree with the health plan's decision to not pay for your care.
Applied to Deductible- Portion of your bill, as defined by your insurance company, that you owe your doctor or hospital.
Authorization Number- A number stating that your treatment has been approved by your insurance plan. Also called a Certification Number or Prior-Authorization Number.

B

Beneficiary- Person covered by health insurance.
Beneficiary Eligibility Verification- A way for doctors and hospitals to get information about whether you have insurance coverage.
Bill/Invoice/Statement- Printed summary of your medical bill.

C

Centers for Medicare and Medicaid (CMS)- The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.
Charity Care- Free or reduced-fee care for patients who have financial hardship.
Claim- Your medical bill that is sent to an insurance company for processing.
Clinic- An area in a hospital or separate building that treats regularly scheduled or walk-in patients for non-emergency care.

COBRA Insurance- Health insurance that you can buy when you lose your job. It is generally more expensive than insurance provided through your job but less expensive than insurance purchased on your own when you are unemployed.
Coding of Claims- Translating diagnoses and procedures in your medical record into numbers that computers can understand.
Coinsurance- The cost sharing part of your bill that you have to pay.
Collection Agency- A business that collects money for unpaid bills.
Contractual Adjustment- A part of your bill that your doctor or hospital must write off (not charge you) because of billing agreements with your insurance company.
Coordination of Benefits (COB)- A provision used to establish the order in which plans pay claims when more than one source exists. COB (Coordination of Benefits): This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy.
Co-payment- A cost sharing part of your bill that is your responsibility to pay. Also known as co-pay.

D

Date of Bill- The date the bill for your services is prepared. It is not the same as the date of service.
Date of Service (DOS)- The date(s) when you were treated.
Deductible- How much cost sharing that you must pay for medical services often before your insurance company starts to pay.
Diagnosis-Related Groups (DRGs)- A payment system for hospital bills. This system categorizes illnesses and medical procedures into groups for which hospitals are paid a fixed amount for each admission.
Discount- Dollar amount taken off your bill, usually because of a contract with your hospital or doctor and your insurance company.
Drugs/Self Administered- Drugs that do not require doctors or nurses to help you when you take them. You may be charged for these. You will need to check with your doctor or hospital regarding their policy on this.
Due from Insurance- How much money is due from your insurance company.
Due from Patient- How much you owe your doctor or hospital.

E

Estimate- An approximate calculation of the amount you will be responsible for paying after insurance.
Explanation of Benefits (EOB/EOMB)- A detailed explanation of payment or denial of a claim made by an insurance carrier. An EOB may also be referred to as a remittance advice.

F

Financial Responsibility- How much of your bill you have to pay.

H

Healthcare Provider- Someone who provides medical services, such as doctors, hospitals, or laboratories. This term should not be confused with insurance companies that "provide" insurance.
Health Maintenance Organization (HMO)- An insurance plan that pays for preventive and other medical services provided by a specific group of participating providers.
HIPAA- Health Insurance Portability and Accountability Act. This federal act sets standards for protecting the privacy of your health information.

I

Insurance Company Name- Name of the company that your claim will be sent to.
Insured Group Name- Name of the group or insurance plan that insures you, usually an employer.
Insured Group Number- A number that your insurance company uses to identify the group under which you are insured.
Insured's Name (Beneficiary)- The name of the insured person.
Internal Control Number (ICN)- A number assigned to your bill by your insurance company or their agent.
In-Network Provider- These are providers that have a contract with your insurance company. If you receive covered services from an in-network provider, generally you will only need to pay your deductible and any applicable copay or coinsurance. You may not be billed for the balance by the provider.

M

Maximum Allowable Amount- The maximum amount that can be reimbursed between all carriers. It is defined service by service based on the line of business (LOB) of the primary carrier (Medicare or commercial) and the status of the provider with the primary carrier.
Medical Record Number- The number assigned by your doctor or hospital that identifies your individual medical record.
Medicare Number- Every person covered under Medicare is assigned a number and issued a card for identification to providers.
Medicare Part A- Usually referred to as Hospital Insurance, it helps pay for inpatient care in hospitals and hospices, as well as some skilled nursing costs.
Medicare Part B- Helps pay for doctor services, outpatient care, and other medical services not paid for by Medicare Part A.
Medicare Secondary Payor (MSP)- If you have traditional Medicare insurance the Federal Law requires that providers of medical services to Medicare beneficiaries determine whether or not there is other insurance coverage for the beneficiary that should be billed before a bill is submitted to Medicare. What does this mean to you? Medicare wants to know if another company is responsible for paying your bill first. During your registration process you will be asked questions to determine if Medicare is the primary or secondary payer. Examples would be worker's comp, car accident, etc.

N

Network- A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.
Non-Covered Charges- Charges for medical services denied or excluded by your insurance. You may be billed for these charges.
Non-Participating Provider- A doctor, hospital, or other healthcare provider that is not part of an insurance plan's doctor or hospital network.

O

Observation- Type of service used by doctors and hospitals to decide whether you need inpatient hospital care or whether you can recover at home or in an outpatient area. Usually charged by the hour.
Out-of-Network Provider- These are providers that do not have a contract with your insurance company. If you receive covered services from an out-of-network provider, the insurance company may pay only a part or none of the charges depending upon the terms of your policy. Also, your copay or coinsurance may be larger than if the services had been provided by an in-network provider.
Out-of-Pocket Costs- Costs you must pay because Medicare or other insurance does not cover them.

P

Paid to Provider- Amount the insurance company pays your medical provider.
Patient Amount Due- The amount charged by your doctor or hospital that you have to pay.
Pay This Amount- How much of your bill you have to pay.

Point-of-Service Plan (POS)- An insurance plan that allows you to choose doctors and hospitals without having to first get a referral from your primary care doctor.
Policy Number- A number that your insurance company gives you to identify your contract.
Prepayments- Money you pay before getting medical care; also referred to as preadmission deposits.
Primary Care Network (PCN)- A group of doctors serving as primary care doctors.
Primary Care Physician (PCP)- A doctor whose practice is devoted to internal medicine, family/general practice, or pediatrics.
Primary Carrier- The carrier that has been determined to be responsible for primary payment by applying the criteria to determine the order of benefits.

R

Reasonable and Customary (R & C)- Billing charges that insurers believe are appropriate for services throughout a region or community.
Release of Information- A signed statement from patients or guarantors that allows doctors and hospitals to release medical information so that insurance companies can pay claims.
Revenue Code- A billing code used to name a specific room, service (X-ray, laboratory), or billing sum.

S

Secondary Insurance- Extra insurance that may pay some charges not paid by your primary insurance company. Whether payment is made depends on your insurance benefits, your coverage, and your benefit coordination.
Specialist- A doctor who specializes in treating certain parts of the body or specific medical conditions. For example, cardiologists only treat patients with heart problems.
Supplemental Insurance Company- An additional insurance policy that handles claims for deductible and coinsurance reimbursement.

U

Units of Service- Measures of medical services, such as the number of hospital days, miles, pints of blood, kidney dialysis treatments, etc.