

## **Eligibility, Payment, and Billing Procedures**

### **Describe a factor that determines patient benefits eligibility.**

One factor that would determine if a patient is eligible for insurance benefits would be to make sure the insurance premiums have been paid on time. Most jobs that offer their employees health insurance usually deduct the insurance premiums from the employee's payroll each pay period, this helps to avoid a lapse in insurance premiums. For plans that are sponsored by the government like Medicaid plans where income is the factor, which decides eligibility the patient's eligibility can change monthly. (Bayes et al., 2008)

### **What are the appropriate steps to take when insurance does not cover a planned service.**

When a planned service is not covered by the insurance the patient will be notified and informed in advance that the service will not be covered, and that the patient will be responsible for paying for services. Some payers require that the Health care provider or physician to use a particular form to tell their patients regarding uncovered services. The financial agreement forms prove patients were told about their obligation to pay the bill before the services are provided and the patient must sign the forms for conformation. (Bayes et al., 2008)

### **Relate these steps to the eligibility factor you identified and provide two examples of patient charges with corresponding billing transactions.**

Example;

- 1) Medical specialist calls patient to inform her she must be financially responsible for her visit on Friday because her insurance has lapsed due to non-payment and will not provide coverage for the visit.
- 2) Ms. Watts a Patient calls the Pinehurst OBGYN Clinic and schedules an appointment for a Pap smear because she has been experiencing unusual spotting. A few days later, the medical insurance specialist from the Pinehurst OBGYN Clinic calls Ms. Watts and explains to her that she can have the Pap smear done; however, she will be responsible for the charges. The specialist explains to Ms. Watts because she has received two PAP smears within a 12 month period Medicaid will not pay for a third. Medicaid will only pay for two PAP smears per year, although it is a preventive service. (Bayes et al., 2008)