

Patient Account Services

Patient Reference & Frequently Asked Questions

Admissions

Each time you present for a new medical service, a new account number will be assigned. You will be asked to pay any patient co pay, coinsurance or deductible either prior to or upon admission.

You must present your current insurance card and picture identification at each service. A copy will be made and kept in your patient folder. If you do not give insurance information at the time of service, your claim may be denied by your insurance company for failure to file the claim timely and then it will be your responsibility to pay the claim.

You may be given an estimate of your total charges. This is not a final bill as you may require additional services that may not have yet been ordered by the physician and provided to you. Please be prepared for possible differences between the estimate and actual bill.

You may need prior authorization or pre-certification for medical treatment. Please discuss this in advance with your physician and insurance company. In some cases, insurance will not pay for hospital costs if patients do not pre-certify the services/treatment with the insurance company. Please remember that merely filing claims with your insurance company does not guarantee the insurance company will pay for your services. You must be certain to comply with the requirements of your particular policy, as described by your insurance company.

Often the patient's insurance policy provides less coverage and requires more to be paid by the patient when services are delivered "out of network," meaning the patient is receiving services from a hospital that does not have a contract with the particular insurance company. The hospital's Registration Department makes a good attempt to notify the patient if the hospital is out of network; however, since the hospital is dealing with hundreds of different insurance contracts, it is always advisable that you check with your insurance company directly for the most current list of in-network providers, meaning those hospitals that have a contract with your insurance company.

Billing

A hospital claim will be sent to your insurance company after you are discharged. Your insurance company will be billed for the charges for the services provided to you.

If you have no insurance coverage, a statement will be mailed to you after discharge. If no payment arrangements have been made within 14 days, you will receive a letter and phone call from our National Patient Account Services.

During your visit to the hospital, you may receive a variety of tests, procedures and services. Many of these services are performed by healthcare providers who work in the hospital and bill for their services separately. After your visit, you may receive bills from several providers, such as your physician,

surgeon, pathologist, radiologist, and anesthesiologist. You should verify with your insurance company that all physicians that treat you are “in-network” providers and are contracted with your insurance company. Below is a listing of the Lab, Radiology and Emergency Room Physicians Billing Services:

Pathology Services

Ameripath North Texas
4350 Alpha Road, Suite 200
Dallas , TX 75244
972.404.9345

Radiology Services Texas Radiology
1600 Coit Road, Suite 307
Plano , TX 75075
972.867.7862

Emergency Room Physicians

Quest Care
P.O. Box 869326
Plano , TX 75086
800.540.0429

To obtain a copy of your itemized charges, please call 866.656.8776. You may request this information through the interactive voice response system and it should be processed within 1 business day. Please have your account number, last 4 digits of patient social security number and date of birth available when you make this call. You may also email CustomerService@Parallon.com .

Coding

All hospital claims submitted to your insurance company have diagnosis and procedure codes. These codes are assigned based on the services your physician ordered, the services performed and the medical record documentation. If your insurance denies your claim for incorrect coding, contact Customer Service at 866.656.8776 and advise them what code is being denied and what code is requested by the insurance company. The account will be sent for coding review. If the insurance company denies a claim for a routine procedure, you must appeal this with your insurance company.

Collections

The collection process begins with our Patient Account Services office in Irving , Texas approximately 30 days after the claim has been submitted to your insurance company. If a claim is not paid in a timely matter, you will receive letters advising you and requesting your assistance in contacting your insurance company. After your insurance has paid the claim, you will receive a letter and call from our National Patient Account Services office in Louisville, KY or Bedford, TX ("NPAS"). This is not a collection agency and does not report to the credit bureau. NPAS will provide you with your payment options. Your insurance company determines the amount that you as the patient must pay based on the

insurance policy you have with them. If you have any questions or concerns regarding this amount, please contact your insurance company. Your primary insurance company must either pay or deny your claim before your secondary insurance company or can be billed.

Much of the correspondence and phone calls that come from the Patient Account Services or NPAS are generated by the computer at pre-set intervals. The timing of these calls and letters is determined by the payment activity or lack of activity on the account. There may be times when a payment and a payment due letter cross in the mail. Calls will be made between 8am and 9pm. If you prefer calls at a particular time, please let the representative know when they make first contact with you.

If your account is not resolved timely, it may be placed with a collection office such as the Outsource Group, Financial Corporation of America or WEST ASSET MANAGEMENT. You will receive a final notice before your account is placed with an agency. Making payments to an account without a payment arrangement will not keep your account from being placed with the agency. You must make a payment arrangement with National Patient Account Services at 800.222.0041 to avoid having your account placed with an agency. If your account is with one of these offices, you must contact them directly for payment arrangements.

The Outsource Group

Three City Place Drive, Suite 690
St. Louis, MO 63141
314.692.6500

Financial Corporation of America (FCA)

P.O. Box 16468
Austin , TX 78761
800.880.8282

West Asset Management

P.O. Box 2308
Sherman , TX 75091-2308
877.370.8739

How do I get a statement showing I have a zero balance?

You can go to Bill Payment & Inquiry at www.themedicalcenterofplanocom/patients-visitors/bill-payment-and-inquiry.dot, enter your account number, social security number of the patient and patient's date of birth, then click on view detail. If your account has been paid in full for more than 45 days, it may be purged from our system.

Contractual Discounts and Adjustments

This is a discount that your insurance company receives with a specific hospital for specific services according to a contract between the insurance company and the hospital.

Dispute Charges

If you have received a copy of your detail bill and you are charged for an item that you did not receive, you will need to complete the audit request form and mail to 10030 N MacArthur Blvd., Irving, Texas 75063. Please be specific regarding the disputed charges. The account will be audited upon receipt of these completed audit request forms and you will be advised of the outcome. Any overcharges or undercharges will be corrected to your account and re-billed to your insurance company. Your co-pay or deductible may not change if your insurance company is contracted to pay based on diagnosis or a specific service rate. To obtain an audit request form, call 866.656.8776 or email CustomerService@Parallon.com.

If you have a dispute regarding the quality of care, please mail a letter of dispute to 10030 N MacArthur Blvd, Irving, TX 75063. Please be specific as to why you are disputing the charges. The account will be reviewed and you will be advised of the outcome.

If you are being charged for a private room and you did not request it, please contact Customer Service at 866.656.8776 by phone or email CustomerService@Parallon.com and advise of the reason this should not be billed. Customer Service will review the account if needed and advise you of the outcome. No audit request forms are required.

Pharmacy Charges are often difficult to understand on your detail bill. Please understand that the quantity reported is **not** the number of doses the patient received. The quantity number reflects the units of medicine contained in a particular dose of medicine. We report the drug in units this way in order for the insurance company to pay us correctly for the drug.

For example, one dose of DRUG A injection for an adult may contain 50 mg of a drug in one syringe (DRUG A 50 mg qty 1 @ \$XXX). The way the hospital is reimbursed for this drug is per each 10 mg of drug given. In order to be paid correctly, we will report a quantity 5 (10 mg x 5 = 50mg) rather than quantity one of 50 mg (DRUG A 50 mg qty 5 @ \$XXX). The charge does not change and the dose hasn't changed; only the way we report the amount of drug given is changed to reflect the actual billing units of the drug (50 mg is the same as 10 mg x5).

If you have been billed for services you did not receive and are a victim of identity theft, we can close the account with a copy of the police report and an Identity Theft Affidavit Form. Please call Customer Services at 866.656.8776 for this form. Mail these documents to Patient Account Services, 10030 N MacArthur Blvd, Irving, TX 75063.

The charges are too high. I have had this service elsewhere for less.

Charges vary at different hospitals and are based on what is considered usual and customary for the area. No account will be audited for this complaint and the charges are considered correct.

Emergency Room Services

Why am I being billed when I left prior to seeing the physician?

Most facilities will charge for beginning a medical screening exam by the nursing staff. This is referred to as a "triage charge." If you disagree with the charges on your account, you may complete the audit request forms and mail these to 10030 N MacArthur Blvd, Irving, TX 75063. Please call Customer Services at 866.656.8776 for this form.

Why am I being billed for a pregnancy test?

In an emergency situation, a pregnancy test will be ordered for any woman of childbearing age.

What are the other bills I am receiving for this service?

You may receive bills from many providers, such as your ER physician, anesthesiologist, pathologist and radiologist. For questions regarding these bills, please contact the provider's office directly.

Estates

What do I need to do if the patient is deceased?

Please mail a copy of the Death Certificate to Patient Account Services at 10030 N MacArthur Blvd, Irving, TX 75063. The account will be billed to the Estate of the Patient or the surviving spouse.

Financial Assistance

You may qualify for financial assistance if you are uninsured or underinsured and have a non-elective emergency service. All Medicare inpatient and outpatient accounts and all non-Medicare inpatient accounts will be required to have supporting income verification documentation. Medicare requires independent income and resource verification for a charity care determination with respect to Medicare beneficiaries. Patients that meet 0-200% of the Federal Poverty Guideline will be considered for qualification under the hospital's charity care policy. Please contact Customer Service at 866.656.8776 to request the Financial Assistance Application.

HIPAA

What is HIPAA / Health Insurance Portability and Accountability Act?

HIPAA is a federal law governing in part how your health information can be used, disclosed and how you can get access to this information. All patients are provided with a copy of the Hospital's Notice of Privacy Practices upon registration or at any time requested. We must verify the identity of any person (including healthcare professionals) or entity from outside our organization when they are requesting protected health information (PHI) either in person, verbally or through a written request. You will need to include the account number, patient social security number and the patient's date of birth.

Insurance

What do I need to follow up with my insurance on my claim status?

You will need the name of the patient, the date of service and the account total charges. You will also need verification information such as the identification number and the patient's date of birth.

If you do not have my correct insurance information, how do I provide that to you?

You may mail your information to 10030 N MacArthur Blvd, Irving, TX 75063, email CustomerService@Parallon.com or call Customer Service at 866.656.8776. We will need the name of the insurance provider, the product (HMO, PPO, Indemnity, POS, etc), name of the insured (which may be different from the patient), policy number, group number, mailing address for claims, and telephone number. It is helpful to forward a copy of your insurance card. If the account has not been written off to bad debt, we will bill insurance; provided, however, if the correct insurance was not provided at the time of service and the claim is denied for late filing, you will still be responsible for the charges. Medicaid is an exception to this rule. If Medicaid information was not given at the time of service, we cannot accept the information for billing after 90 days in Texas.

IVR (Interactive Voice Response)

What services are available to me on the IVR system?

You may get your account balance, information regarding patient or insurance payments posted to the account, request a copy of your itemized bill, and any needed mailing address. The IVR is available 24 hours, 7 days a week and 365 days a year. The phone number is 866.656.8776.

Late Charges

Charges for treatments and medications ordered within 24 hours of your discharge may not be included on your initial bill.

Medical Records

How may I get a copy of my medical records?

You need to contact the hospital Medical Records Department at 972.519.1443. Your medical records are available for your review. There may be a fee for copies of records.

How can my insurance get a copy of my medical records?

We must receive a written request on letterhead stationary from your insurer.

Medicare

When is Medicare not primary?

1. If you are 65 or older and currently working with coverage under an employer with a group health plan.
2. If you are 65 or older and are covered by a working spouse's employer group health plan.

3. If you are under 65, disabled, and covered by a large group health plan due to your own or family member's current employment status.
4. With kidney failure, Medicare is secondary during the Coordination of Benefits period if you have coverage under your or other family member's employer group health plan. The COB period is 30 months.
5. If you receive services covered under Worker's Compensation, Federal Black Lung, automobile, no-fault or liability insurance plans.
6. If you receive services covered under the Veteran Administration.

If Medicare has wrong information on file, what do I need to do?

You must go to their nearest Social Security Office or call 800.772.1213 to find the nearest office to you, to have their records corrected. You may also call Medicare at 800.999.1118.

What are the Medicare non-covered charges that have been billed to me?

1. "Self administered medications" are not covered by Medicare. As of November 17, 2004 these charges are included on your claim to Medicare. Medicare will deny and the charges will be forwarded to any secondary payor, if any, for consideration. Prior to November 17, 2004, we were unable to bill these to Medicare without the patient's request. If you have charges prior to this date that you would like a secondary payor to consider, please contact Customer Service and request they be billed.
2. Certain laboratory, radiology and cardiovascular test for which you have signed an Advanced Beneficiary Notice.
3. Other non-covered charges deemed by Medicare such as foot care, denial care, cosmetic services and other services specifically indicated by Medicare.

If Medicare has paid, what is this balance?

Medicare Part A has an inpatient deductible per spell of illness and outpatient coinsurance. There is a co-payment for Skilled Nursing Facility charges for days 21 through 100. Medicare Part B has an annual deductible and various co-payment amounts.

What are Medicare Part A and Part B?

Part A is hospital (inpatient) insurance. Part B is medical (outpatient) insurance.

Who is Mutual of Omaha?

Medicare contracts with large insurance companies (for example, Blue/Cross/Blue Shield and Mutual of Omaha) to process their Medicare claims. Our contract is with Mutual of Omaha. You may see Mutual of Omaha - Medicare on your statement.

Minor Children

Who is responsible for my child's hospital bill?

In the state of Texas, both parents are responsible for the minor child's bill. The parent signing the Consent for Treatment will be listed as the responsible party if possible. The responsible party will not be changed. If a court order determines one parent should pay medical expenses, the parents should make this arrangement between themselves. We can add a second parent as a responsible party if requested.

When is a minor considered emancipated?

A child that no longer requires parental guidance or financial support, has fathered or given birth to a child, or has reached the age of majority is considered emancipated and responsible for their charges.

Newborn Accounts

All newborns will have their own account number. All babies will also receive a bill for their own room charges, even though they may have stayed much of the time in their mother's room.

Birth Certificates will be filed with the state no more than 5 days after birth. Any changes to the Birth Certificate that are requested after the filing are the responsibility of the parents and must be done through the County Clerk's Office or the State Department of Vital Statistics. A copy of the Birth Certificate may be obtained by contacting the County Clerk's Office or the State Department of Vital Statistics.

Online Services

Can I view or pay my account online?

Yes, you will need your account number, the patient's date of birth and the patient's social security number. Website is www.themedicalcenterofplano.com/patients-visitors/bill-payment-and-inquiry.dot.

Can I contact Customer Service via email?

Yes, email CustomerService@Parallon.com

Out of Network

My insurance company states I should get an in network discount and you are not providing it.

Please mail a copy of your Insurance Explanation of Benefits to 10030 N MacArthur Blvd, Irving, TX 76053 with this discount shown. In order for your insurance to take an in network discount, this network logo must be on your insurance card and a contract must be in effect. Please include a copy of the card with logo if possible.

My insurance is processing the physician bill without a discount because the physician is out of network. I went to your in network hospital and you selected the physician, so why is this happening?

Insurance contracts are negotiated separately between hospital and physician. The hospital and physicians try to mirror their contracts as much as possible. You should appeal for additional payment with your insurance.

Patient Responsibilities

If you are insured, you will have one or more of the following:

Coinsurance : A form of cost sharing. After your deductible has been met, the insurance company will begin paying a percentage of your bills. The remaining amount, known as coinsurance, is the portion owed by the patient.

Deductible : Provisions that require the member to accumulate a specific amount of medical bills before benefits are provided. For example, if a member's policy contains a \$500 deductible, the member must accumulate and pay \$500 out of pocket before the insurance company will pay.

Copay : A set fee the member pays to providers at the time services are provided. Copays (or copayments) are typically applied to the emergency room visits, hospital admissions, office visits, etc. The cost is usually minimal.

Patient Type

Why am I considered an outpatient when I stayed in a hospital room?

You may have been in the hospital for observation. Observation services usually do not exceed 48 hours; however, there is no hourly limit on the extent to which they may be used. This is not an admission to the hospital as an inpatient. The determination to admit for observation or as an inpatient is made by the attending physician and is based on medical necessity. If you believe that you have been incorrectly coded in this regard, please complete the audit request forms and forward to HCA Patient Account Services, 10030 N MacArthur Blvd, Irving, TX 75603. Please contact Customer Service at 866.656.8776 or CustomerService@Parallon.com to receive audit request forms. We will review your account and advise you of the outcome.

Payment Arrangements

Can I make payment arrangements?

Yes, you must contact Customer Service and request this arrangement at 866.656.8776. There is a minimum payment due according to your account balance.

Payment Options

What are my payment options?

You can pay your account in person by cash, check or credit card, over the telephone with a credit card or check or online at www.themedicalcenterofplano.com/patients-visitors/bill-payment-and-inquiry.dot with a credit card.

Refund Requests

Will I receive my insurance company's overpayment?

Insurance company overpayments are refunded to the insurance company.

What will happen to my credit balance if I have an open account?

Your credit will be transferred to any accounts with open balances. If there are no outstanding balances, a refund will be issued to you.

Who is the refund made payable to?

The refund is made payable to the payor on the account.

Uninsured Discount

All Self Pay patient accounts, excluding elective cosmetic procedures, flat rate procedures and scheduled/discounted procedures for International patients will be given an Uninsured Discount.