ENDOCRINE ASSOCIATES FINANCIAL POLICY

Our office will submit your medical claims to the insurance company that you provide as a courtesy to you if we are in network with your insurance. It is your responsibility to verify your benefits, coverage, and ***network participation*** with your insurance company for all services rendered by our physicians.

Please check our website (www.endomclean.com) for a list of our in-network insurance plans. In order for us to process the claim on your behalf you must provide our office staff the correct insurance information, a copy of your insurance card (front and back), and all necessary information or additional forms. Your insurance policy is a contract between you and your insurance company. It is ultimately your responsibility to know the status of your account.

If your insurance company has not paid your account within 60 days, the balance will be billed to you. **It is also your responsibility to inform our office staff of any changes in your insurance information at the time of service.** In the event you provide your insurance information after an insurance carrier's imposed "timely filing limit" we will be unable to file a claim on your behalf and you will be responsible for all charges incurred.

- **INSURANCE PLANS THAT USE SOCIAL SECURITY NUMBERS:** If your plan uses the subscriber's SSN as an identifier such as **ALL Local Trust Funds and Unions**, we will need the subscriber's social security number on file in order to process your claim even if the subscriber ID number is unique on the insurance card. We cannot call and obtain claim status without the subscriber's SSN. We will **not require** the subscriber's SSN at registration, but if an issue arises where we cannot obtain claim status without this information, we will attempt to call you once to obtain it. If we are not successful in obtaining the subscriber's SSN, we will turn the balance over to you.

- **Co-payments:** **ALL** co-payments are due at the time services are rendered. Our office accepts checks, debit cards, MasterCard, Visa and American Express. Sorry, we do not accept cash!

- **Co-payments Waiver Cards:** If you provide your copayment waiver card, we will NOT collect your copayment on the date of your visit. We do NOT file claims on copayment waivers. Your insurance should process the claim after it's been paid and your copayment should automatically be paid as "secondary". If there is ANY remaining balance after the copayment waiver has been paid, you will be billed and you will have to work the balance out with your insurance.

- **Co-Insurance and/or Deductibles:** Our office will send you a statement within 30 days of receiving payment from your insurance if they have applied coinsurance and/or a deductible to your claim.

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- **Secondary Insurance Plans:** Our office will submit secondary claims on your behalf if we are IN NETWORK only with the exception of Medicare or Tricare supplement policies. In those cases, we will submit on your behalf unless for example you have Kaiser HMO. In that case, we will not bill your secondary as Kaiser HMO is out of network and they do not pay as secondary even if Medicare or Tricare is primary.

- **Aetna/Innovation Health HMO Patients:** Our office will not be able to see you until we have a current referral on file from your PCP (if on the back of your insurance card, it says a PCP referral is required). Remember that most referrals are only valid for a certain amount of visits and a limited period.

- **Anthem and Carefirst plans:** Our local BCBS carrier is Anthem, so all claims regardless if you have Anthem or Carefirst, gets billed to Anthem. We will attempt to bill your Carefirst claim to Anthem. If for any reason, there is an issue in receiving reimbursement from Anthem for your Carefirst membership, we will attempt to resolve the matter. If we are unsuccessful in doing so, you will be balance billed.

- **Medicare Patients:** Our physicians participate in the Medicare program and Railroad Medicare. If you have Medigap coverage, please provide that at the time of registration.

- **MultiPlan / PHCS patients:** Our physicians participate with MultiPlan and PHCS, but it's very limited to what plans we are in network with. For example, we are **out of network** with "Practitioner Only" plans, "Limited Medical Plans", "Complimentary" plans, and "Value Point"plans. If you are unsure about our network participation with your plan, call your insurance company for a list of in-network providers.

- **Tricare *PRIME* Patients:** Please call ahead to verify that you have a current, valid referral on file with our office from your PCM. Remember that most referrals are only valid for a certain amount of visits and a limited period. Our office will not be able to see you until we have a current referral on file.

- **Appointments:** We make every effort to meet our patients' needs in scheduling appointments. All visits with the physicians are by appointment only and we request that patients arrive promptly. If you must cancel or change your appointment, our policy requires that you contact us at least 24 business hours in advance so that other patients may be accommodated. If 24 hour notice is not given a cancellation/reschedule fee of $35.00 for follow up appointments or $95.00 for new patients may be assessed.

- **Administration Charges:** Charges may apply to some "non-covered" services. These may include but are not limited to: prescription refills, drug authorizations, completion of certain forms and photocopying of medical records.

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AUTHORIZATION

I hereby authorize Frank R. Crantz, M.D. or S. Mark Tanen, M.D., LLC to apply for benefits on my behalf (or my child's) for services rendered. I also hereby authorize payment of the insurance benefits, otherwise payable to me directly, to the doctor.

I authorize the release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I agree to be responsible for all charges not covered by my health insurance.

I understand that I will be held financially responsible for all costs involved with the collection of monies for this account. This includes collection fees, court costs, and reasonable attorney fees.

I have read and understand the above information. I understand I am responsible for charges incurred from services rendered.

PATIENT SIGNATURE _____DATE _____

PATIENT NAME (PRINTED) _____ DATE _____