



Understanding Insurance and Medical Billing Terms

The following are the most common terms associated with insurance plans and medical billing.

Actual charges	The amounts charged by the physician for a specific service. This amount is often more than the amount an insurance plan approves.
Appeal	A process by which a patient or the hospital can object to an insurance company when disagree with the insurance plan's decision to not pay for patient care.
Authorization	Approval of care by the insurance company before a service is provided. Pre-authorization may be necessary before hospital admission, or before care is given by physicians not approved by insurance plan.
Adjustment	The portion of a patient's bill that the physician or hospital must not charge you because of billing agreement with the insurance company.
Allowable charges (UCR charges)	The amounts an insurance company is willing to pay for a specific service – "usual and customary" charges. Amount is usually determined by geographic location of the provider.
Ambulatory/ Outpatient Surgery	Surgery done in the doctor's office or at a surgical center, not requiring an overnight stay.
Ancillary Services	Services over and above physician services, including laboratory, radiology, home health and skilled nursing facilities
Applied to Deductible	Portion of your bill, as defined by your insurance company, that you have to pay.
Assignment of Benefits	A form signed by patient to have insurance payments sent directly to physician, hospital or other services.
Attending Physician	The physician who certifies that you need treatment and is responsible for your care.
Balance Billing	How much the patient owes after their health plan, insurance company or Medicare have paid its approved amount for services.
Beneficiary	Person covered by health insurance.
Claim	A record of medical services provided to a patient and submitted by the provider to the insurance company for payment.
Claim Review	The method by which a patient's health care claims are reviewed before the reimbursement is made. This is done to validate the appropriateness of services given and that the cost is not excessive.

COBRA Insurance	Health insurance that a person can buy when they lose a job. It is generally more expensive than insurance provided through an employer but less expensive than insurance purchased individually when unemployed.
Co-insurance	The percentage a patient will be responsible to pay for a specific service as determined by their insurance plan.
Coordination of Benefits (COB)	A way to decide which insurance company is responsible for payment if person has more than one insurance plan.
Co-payment	The amount a patient is required to pay for a visit/service to a physician/provider. Usually the patient is only responsible for copayments at a participating provider. This fee does not vary with the cost of the service.
Covered Benefit	A health service or item that is included in a health plan and that is partially or fully paid by the health plan.
CPT Codes (Procedure Code)	The coding system used to describe what treatment or services were provided. This code is universal and dictates the payment allowances.
Date of Service (DOS)	The date(s) when a patient received treatment.
Date Processed	The date the bill for a patient's services is prepared. It is not the same as the date of service.
Deductible	The amount an insured member must pay before the insurance company pays benefits. Amounts that are not covered by plan are not applied to the deductible. Generally, each patient will have his or her own deductible to meet.
Diagnosis Code (ICD-9)	A 3 to 5 digit number code, used for billing describing a diagnosis or medical procedure.
EOB (Explanation of benefits)	The notice a patient receives from their insurance company after getting medical services from a doctor or hospital. It states what was billed, the payment approved by insurance, the amount paid, and what patient needs to pay.
Estimated Insurance	Estimated cost paid by the patient's insurance company.
Exclusion	Services or supplies not covered under a health plan.
Fee Schedule	A listing of the maximum fee which a health plan will pay for services based on the CPT billing codes.
Group	Name of company that insures a person, usually an employer.
Group Number	A number that your insurance company uses to identify the group under which you are insured.
Health Maintenance Organizations (HMO)	An insurance plan that pays for preventive and other medical services provided by a specific group of participating providers (network). A patient must choose a primary care physician, see only network physicians, and get referrals from primary care physician to see specialists outside the network.
Healthcare Provider	A physician, hospital, laboratory, pharmacy or other organization that provides health care, goods or services.
HIPAA	Health Insurance Portability and Accountability Act. This federal act sets standards for protecting the privacy of your health information.

Home Health Agency	An agency that treats patients in their homes.
Hospice	Group that offers inpatient, outpatient and home healthcare for terminally ill patients.
Inpatient	A patient who is admitted to a hospital and receives medical services from a physician during a least a 24-hour period.
Itemized Bill	Printed summary of a patient's medical bill.
Long-Term Care	Care received in a nursing home.
Managed Care	An insurance plan that requires members to see doctors and hospitals that have a contract with the insurance company (called a network). Payment for services depends on the network's rules.
Medicaid	A state-administered, federal and state funded insurance plan for low-income people who have limited or no insurance.
Medical Record Number	The number assigned by the hospital that identifies a patient's individual medical record.
Medical/Surgical Supplies	Special supplies, such as materials used to repair a wound or instruments used for patient care.
Medicare	The federal health insurance program for people age 65 and older.
Medicare Approved	Medical services for which Medicare normally pays.
Medicare Assignment	Doctors and hospitals that have accepted Medicare patients and have agreed not to charge them more than Medicare has approved.
Medicare Number	Every person covered under Medicare is assigned a number and issued a card for identification to providers.
Medicare Paid	The amount of a patient's bill that Medicare paid.
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 care.
Medicare Part B	Helps pay for doctor services, outpatient care, and other medical services not paid for by Medicare Part A.
Medicare Part D	Helps pay for prescription drugs.
Network	A group of physicians, hospitals, pharmacies and other health care experts who are contracted with an insurance/health plan to take care of its members.
Non-Participating Provider	A physician, hospital, or other healthcare provider that is not part of an insurance plan's network.
Out-of-Pocket Costs	Costs a patient must pay because Medicare or other insurance does not cover them.
Outpatient	A patient who receives health care services, but is not admitted to a hospital during a 24-hour period.
Point of Service	An insurance plan that allows patient to chose between an HMO or a PPO each time services are needed. Patients must choose a primary care provider.
Pre-Certification	Also known as pre-admission, certification is the process of obtaining authorization from the insurance plan for routine inpatient and outpatient admissions. Failure to obtain this may result in a penalty to the provider or the subscriber.

Pre-existing Condition	A health condition or medical problem that a person already has prior to signing up to receive insurance. Some health insurers may not pay for pre-existing health conditions.
Preferred Provider Organization (PPO)	An insurance plan that pays more for medical services if provided by physicians within the network, but will pay only a portion for services provided outside of the network. Referrals to specialists not needed if is part of the network.
Primary Care Physician	A physician, usually a general, family practitioner or internist, who delivers general health care, and is most often the first doctor a patient sees. This physician treats the patient directly, refers them to a specialist (or secondary care physician) or admits them to the hospital.
Primary Insurance	The insurance company responsible for paying your claim first. If you have another insurance company, it is referred to as the Secondary Insurance.
Reason code	An explanation of why a service has been denied or why an amount is not covered.
Referral Authorization	Approval for a member to see a physician or access services outside of the participating medical group.
Referral Physician	A physician who sees a patient after another doctor has sent them for specialty care or services.
Referring Physician	A physician who sends a patient to another doctor for specialty care or services.
Subscriber	A person who enrolls in an insurance/health care plan and agrees to pay for premiums, co-payments and deductibles that are part of the plan.
Treating Physician	A physician who provides care to the patient while in the hospital, and usually works at the hospital or comes in as a specialist.
Workers Compensation	Workers' compensation is insurance, paid by employers, that provides cash benefits and medical care if an employee becomes disabled because of an injury related to the employee's job.

Note: This reference sheet is intended as a guide for a discussion with your insurance company. Terms and intentions are subject to interpretation within insurance companies.

References: www.baptisthealth.net
www.patientadvocate.org
www.mesothelioma-aid.org/insuranceglossary.htm

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