ADVENTHEALTH SURGERY CENTER ORMOND BEACH		
SUBJECT: INSURANCE VERIFICATION/PRE-CERTIFICATION Page 1 of 1		
POLICY: BO-	**EFFECTIVE DATE:**	**DATE REVISED: 6.2024**

PURPOSE:

To provide guidelines for timely and accurate verification of third party payor eligibility, benefits, and precertification

POLICY:

A. The Physician Scheduler will contact the insurance carrier to obtain verification of benefits at least three days prior to procedure, but no earlier than three weeks prior to procedure.

PROCEDURE:

A. The Center's business office staff will verify at least 3 days prior to day of procedure that insurance verification has been completed.

B. For add-on patients on the day of procedure, verification must be done that day prior to the time of procedure.

C. The insurance verification includes eligibility, benefits, pre-certification (if applicable) and verification of all insurance information, i.e., patient's identification, group numbers, name of insured, claims address, etc. All additional information obtained will be entered into computer by the insurance verifier.

D. The insurance verifier will obtain approval for any deviation of coverage from Administrator, i.e., non-participating contract, large deductible needing payment plan, etc.

E. Verification of insurance coverage, i.e., primary and secondary insurance coverage is completed on all patients.

    1. Verification of secondary insurance coverage for patients with Medicare as primary insurer is not required.

F. After insurance verification is complete, if monies are owed by the patient, i.e., copays, deductibles, self-pay, etc., the insurance verifier will give the completed insurance verification form to the patient financial counselor.

    1. All information regarding collection of these payments should be entered into computer.

G. At the time of admission, all information will be verified with the patient for accuracy by the receptionist. Any necessary changes or corrections will be entered into the computer by the receptionist at that time.

H. Information about required co-pays and/or deductibles on DOS will be entered into the computer.

ADVENTHEALTH SURGERY CENTER ORMOND BEACH		
SUBJECT: PATIENT FINANCIAL COUNSELING Page 1 of 1		
POLICY: BO-	**EFFECTIVE DATE:**	**DATE REVISED: 6.2024**

PURPOSE:
To describe parameters for appropriate, adequate and timely patient financial counseling.

POLICY:

A. The Center completes financial counseling for all patients scheduled for a procedure at the Center that will have a financial payment responsibility.

B. Upon completion of insurance verification, the insurance verifier will forward information regarding deductibles, co-pays, self-pays, etc. to the patient financial counselor. The information is also entered into EPIC system.

PROCEDURE:

A. The patient financial counselor will contact the patient (or responsible party if the patient is a minor) at least three days but preferably one week prior to the date of procedure to inform the patient of his/her financial responsibility and respond to any and all questions regarding the patient's insurance coverage as determined during insurance verification for the scheduled procedure.

B. Patients will get a text or email automatically about their responsibility if they have signed up for digital alerts.

C. Co-pays and deductibles are due on the day of procedure. If the patient cannot afford these payments due, then a payment plan can be requested by Business Office Staff to Revenue Cycle.

D. Payment in full should be requested from the patient on the date of service. Payment can be made by cashier's check, credit card, money order, or cash.

E. Self-pay patients are expected to pay in full by the date of procedure unless a payment plan has been arranged with Revenue Cycle.

F. Patients and prospective patients may request from this facility and other health care providers a more personalized estimate of charges and other information. An estimate or an update to a previous estimate shall be provided within 7 business days from receipt of the request.

G. Any other payment arrangements must be made with the written approval of the Administrator and Executive Director. No patient should be denied care without approval of the administrator or designee.

H. If the patient needs Charitable Consideration, then the patient will be requested to complete the Charitable Worksheet. (**Refer to Financial Assistance Policy)**

I. For services not covered by Medicare, the patient must be made aware of their responsibility and sign a properly completed Advanced Beneficiary Notice (ABN) or Notice of Exclusion of Medicare Benefits (NEMB).

ADVENTHEALTH SURGERY CENTER ORMOND BEACH		
SUBJECT: PATIENT FINANCIAL RESPONSIBILITIES		
POLICY: BO-	**EFFECTIVE DATE:**	**DATE REVISED: 6.2024**

PURPOSE:

To support the rights of patients in understanding financial issues and their financial responsibilities

POLICY:

A. All patients are informed of the facility's policy regarding payment of services.

B. Patients may receive an estimate and explanation of fees for proposed plan of treatment. The patient will be informed of any deductible and/or copayment prior to procedure. Facility policy requires that this patient responsibility is paid in advance of procedure unless other arrangements have been made.

C. Unless payment in full for procedure is obtained in advance, the patient will be required to assign all insurance/Medicare payments to be paid directly to the facility.

D. Patients will receive a Statement of Charges within 7 days after DOS regardless of source of payment.

PROCEDURE:

A. When a patient has decided to undergo treatment, the patient's insurance benefits will be verified. If a deposit is required, it is collected, documented, and a receipt given to the patient.

B. At the time of pre-admission or admission, the patient will sign an Authorization for Insurance/Medicare Benefits form assigning all insurance/Medicare payments to be paid directly to the facility.

C. The Administrator and Executive Director reviews requests for special payment arrangements and documents specific arrangements for satisfying charges.

D. The insurance verification and/or financial counselor staff are responsible for entering notes regarding pertinent billing, collection, and insurance information received from the patient into software billing module.

ADVENTHEALTH SURGERY CENTER ORMOND BEACH		
SUBJECT: BILLING OF FACILITY FEES-		
POLICY: BO-	**EFFECTIVE DATE:**	**DATE REVISED: 6.2024**

PURPOSE:

To provide guidelines for the accurate and timely billing of facility fees to third party payers

POLICY:

A. Coding, Billing and Collection Services is performed by Revenue Cycle Services at AdventHealth Daytona Beach.

PROCEDURE:

A. All fees for service will be entered on a daily basis within 48 hours of date of procedure.

B. All payers who accept electronic filing should be processed in this manner.

C. All billing information is documented in the EPIC software in the appropriate module.

D. Patient statements are generated automatically from EPIC once all payers have adjudicated a claim.

E. For any outstanding balances a statement is generated after charges are posted to the account.

F. Patients do get a text or email for balances if they have signed up for digital alerts.

G. Per Florida regulations an initial post-treatment statement will be sent seven (7) days after the DOS.
    1. This statement will prominently display the Center’s patient liaison name and telephone number.
    2. If the patient requests their medical record to verify the charges, the Center must send the medical record to the patient within 10 days from the request.
    3. If the patient has any questions regarding their statement or bill, the Center is required to respond within seven (7) days after the date a question is received.

H. The patient has a right to dispute charges that appear on the patient's itemized statement or bill. This facility will provide an initial response to any patient grievance within 7 business days after the patient formally files a grievance disputing all or a portion of an itemized statement or bill.