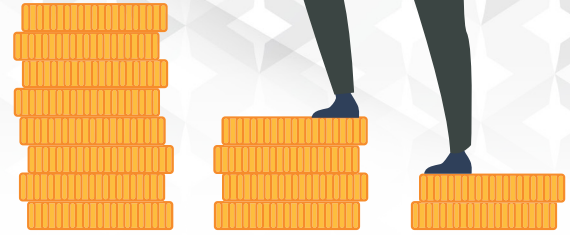


NAVIGATING THE PATIENT FINANCIAL JOURNEY

Information powered by Ensemble Health Partners®



Your physician or care provider orders your test or procedure.

Your demographics & discuss financial obligations, if any.



A clinical team member may call you to prepare for your test or procedure. (or you may skip this step)



It's time to go to the Hospital! You will need:
• Your Physician Order, Current Insurance Card & Photo ID



Time for your procedure!



You are ready to go home!



Your visit is reviewed by your insurance company (if insured) & you will receive an Explanation of Benefits (EOB)



You may receive a statement from with information on how you may pay your bill. This statement should, in most cases, match your EOB.



A Customer Service Representative (CSR) is waiting to answer any questions you may have.



Contact us to learn more at:

GLOSSARY OF TERMS

1 EOB - Explanation of Benefits:

A statement sent to you by your health insurance company explaining what medical treatments and/or services were paid for on your behalf.

2 Deductible: The amount you pay for covered healthcare services before your insurance plan starts to pay.

3 Co-Pay: A fixed amount you pay for a covered healthcare service after you have paid your deductible.

4 Co-Insurance: The percentage of costs of a covered healthcare service.

5 Out-of-Pocket: The portion of your covered medical expenses that you can expect to pay during the course of a plan year.

6 Estimate: The total amount you may have to pay for services, which is calculated before you receive your services.

7 Coordination of Benefits: A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.

8 Medically Necessary: Healthcare services or supplies needed to diagnose or treat an illness, injury condition, disease or its symptoms, and that meet accepted standards of medicine.

9 Pre-Authorization: A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Pre-authorization is not a promise your health insurance or plan will cover the cost.

10 Appeal: A request for your health insurer or plan to review a decision or grievance again.

11 ABN - Advanced Beneficiary Notice: A Medicare waiver of liability that providers are required to give a Medicare patient before services if, based on Medicare rules, those services may not be covered or considered medically necessary.

12 Denial: When an insurance company does not approve payment for a specific claim or does not pre-authorize a service or services before you have received the healthcare service.

Contact us to learn more at: