NAVIGATING THE PATIENT FINANCIAL JOURNEY

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Your physician or care provider orders your test or procedure.

Your [Pre-Service Coordinator] will call to validate 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 [Ballad Health] 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:

Email@EnsembleHP.com | 000-000-0000

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.

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