EMPLOYEE BENEFITS SERVICES

# FREQUENTLY ASKED QUESTIONS

## A PROVIDER IS STATING THAT THEY DO NOT ACCEPT MY INSURANCE, WHAT DO I DO?

Often this happens because the provider does not recognize the logo on your ID card. Explain that your health benefits can be verified by contacting your Claim Administrator at the toll-free number on the ID card.

## COULD THE PROVIDER ASK ME TO PAY FOR MY CARE IN ADVANCE?

The provider may request payment from you in advance, but as the patient, you are only responsible for your out-of-pocket amount (co-pay, coinsurance deductible). Pay your co-pay in advance as the coinsurance and deductible are not calculated until your administrator processes the claim.

## WHAT IF THE PROVIDER ASKS ME TO PAY MORE THAN MY OUT-OF-POCKET?

Your plan does not require you to pay for care in advance beyond your out-of-pocket responsibility. If the provider refuses to treat you, please contact your Claim Administrator so they can speak to the provider.

## WHAT SHOULD I DO IF I GET A BALANCE BILL?

Contact AMPS immediately at (800) 425-9373. Be prepared to send a copy of the front and back of the hospital statement to your Patient Advocate. Once the invalid balance is verified, your Patient Advocate will send you a Balance Bill Kit.

## WHAT IS A BALANCE BILL KIT?

A Balance Bill kit includes an Authorization Letter, Telephone Call Information Form, the Formal Notice Regarding Billing Errors and Dispute of Charges, and the Collection Agency Rules List. The Authorization and the Formal Notice should be signed and returned to AMPS as soon as possible.

## IS THERE A DEADLINE FOR DISPUTING A BALANCE BILL?

Under the Fair Credit Billing Act (FCBA), you have 60 days to dispute an invalid balance with the provider.

## ONCE NOTIFIED OF THE DISPUTE, WILL THE PROVIDER STOP SENDING BILLS?

You will probably continue to get a statement from the provider every month. Providers are large, and their billing is automated, so it’s very difficult for them to interrupt a single statement.

## CAN I ASK A PROVIDER OR THEIR REPRESENTATIVE TO CONTACT AMPS INSTEAD OF CALLING ME?

Yes. If you receive a call about charges that have been disputed, you can ask the caller to contact AMPS at (800) 425-9373. Tell the caller that you have appointed AMPS as your Authorized Representative.

## HOW LONG DOES IT TAKE TO RESOLVE AN INVALID BALANCE BILL WITH THE PROVIDER?

It can be a lengthy process. Even working within the federal guidelines, it can take several months to resolve an invalid balance. Most are resolved in 12 – 18 months from the first balance bill.

## WHAT IF I NEED ADDITIONAL TREATMENT AT THIS HOSPITAL/SURGERY CENTER?

Will they turn me away? It has not been AMPS experience to have a provider turn away a member due to balance billing. If you encounter any admissions issues, please call your Claim Administrator right away so that they and AMPS can work together to resolve the issue.

## SHOULD I MAKE ANY PAYMENTS ON THE BILL I RECEIVE?

Pay only the balance you owe. If you cannot pay the entire balance at one time, make payment arrangements on the balance owed, or make a monthly, good faith payment against it. Never sign a payment plan or verbally agree to pay an amount that is greater than what you owe.

## CAN MY CREDIT SCORE BE AFFECTED?

If the dispute is filed within 60 days, the likelihood of your credit being affected is greatly reduced. Despite our efforts, you may still be contacted by bill collectors. Should this happen, please see the “Collection Agency Rules List” included in the Balance Bill Kit, to be aware of your rights. The hospital will be notified that under the Fair Credit Reporting Act (FCRA), it is a violation for them to report your account to a credit reporting agency or Credit Bureau.

## WHAT IS RBR?

RBR stands for Reference Based Reimbursement. This is a method of reimbursement based on several pricing benchmarks including Medicare, true costs and cost-to-charge data.

## HOW WILL I KNOW IF I AM BEING BALANCE BILLED OR IF THE AMOUNT ON THE HOSPITAL STATEMENT IS MY RESPONSIBILITY?

The EOB (Explanation of Benefits) from your Claim Administrator contains a box that shows how much you owe. When you get the first hospital statement, compare the amount they are billing to your EOB. If the amount on the hospital statement is more than that on your EOB, you are being balance billed.

## WHEN DOES THE 60-DAY TIMELINE START FOR FILING A DISPUTE?

The 60-day timeline begins on the date stamp on the envelope of the first statement you receive from the hospital. If you did not keep the envelope, it begins on the date on the first statement you receive from the facility.

## CAN I STILL CONTACT AMPS IF MY BALANCE BILL IS OLDER THAN 60 DAYS?

Yes. While our effectiveness is reduced outside the FCBA 60-day period, we will still fight to protect you as best we can.