Explanation of Your Insurance and Billing Summary

To ensure that any questions you may have about the billing of your insurance company are answered, we have prepared this overview of the insurance billing process. Although it is the **patient's responsibility to know and understand their insurance coverage** we are here to help in any way we can. Our office does not make the rules/policies between you and your insurance company and it is **up to each patient to discuss any misunderstandings or appeals directly with your insurance company.**

Definitions

Deductible – the amount that must be paid by each patient each year for health care expenses before the insurance company begins to pay. This includes patients covered by Medicare.

Coinsurance – Many insurance plans require patients to pay a portion of their health care costs after first meeting the deductible. This coinsurance is usually a percentage of the total fee up to the patient's out-of-pocket limit. This includes patients covered by Medicare.

Out-of-Pocket Limit – Most insurance plans will pay all the costs after the deductible and coinsurance limit is met.

Secondary Insurance – Some patients are covered by more than one insurance plan. Secondary insurance carriers are billed only after the primary insurance carrier has paid their portion of the covered expenses. Secondary insurance *may possibly* cover the deductible and coinsurance amounts not paid by the primary insurance.

Preauthorization – Many insurance carriers require that some procedures be pre-authorized. A pre-authorization will determine if the proposed procedure is a covered expense under your insurance plan. Our office will call your insurance carrier to make this determination. Pre-authorization from your insurance carrier does ***not*** guarantee their payment, but *usually* means they will do so.

Vision Plan vs. Medical Insurance – Eye doctors are the only health care providers that must follow two different sets of insurance regulations. When you have both types of insurance, the **reason for your visit, your chief complaint, your history of present illness and whether the visit was recommended by a physician dictates which insurance covers your visit**. A vision supplemental plan covers only visits for a patient that has **NO** signs, symptoms, complaints or previous diagnosis of conditions and just wants new glasses or contact lenses. However, if there is a sign, symptom or complaint (such as red eyes, blurred vision, tired eyes, headaches, eye irritation, dry eyes, itchy eyes, flashes, floaters, etc.) or diagnosis of a previous problem (e.g. diabetes, glaucoma suspect, cataract, prolonged use of medicine, dry eyes, etc.) **then your medical insurance covers your visit. A vision discount plan DOES not cover any medical eye conditions.**

Billing & Collections

After your exam we will bill your insurance carrier. Your insurance carrier will review the bill and, in most cases pay their portion within 90 days. If you have secondary insurance, that carrier will be billed after we obtain payment from the primary carrier.

We will collect any deductible and/or coinsurance amounts due to Master Eye Associates at the time of your visit.
We are required by law to collect all co-payments, coinsurance and deductibles. Although we will make every effort to collect from your insurance carrier, you are ultimately responsible for the payment of your fees in full. A service fee is charged for all returned checks and/or credit card chargebacks. A rebilling fee will be added to every invoice sent if we are not able to use the credit card provided to us for the pre-authorized payment. You will also be responsible for the costs of fees charged by attorneys or a collection agency for the cost of collection if such action is taken because your bill is unpaid for over 60 days from the date of service.