Singing River Health System

Patient Financial Service Center

Frequently Asked Questions

We, at Singing River Health System, appreciate the opportunity to serve your health care needs. We understand hospital billing practices can be confusing. We are here to help. Below are a few of the most commonly asked questions. You can use the jump to question links below or scroll down the page to read all the questions and answers.

What is the Pre-Arrival program?

For your convenience, we have a pre-arrival program that will help make your visit to Singing River Health System go smoother. During this pre-registration process we will ask a series of questions which will include insurance information to help your bills get processed quickly and accurately. This information will be kept strictly confidential. It will also allow us to give you an estimated cost for services that your insurance does not cover.

What should I expect during Registration/Admissions?

On the day of your admission, be sure to bring your insurance card or a copy of the front and back of the card with you that day. The information you will be asked to provide includes: physician name, your name, sex, maiden name or other married names admitted under previously; address, phone, employer, name of relative or other contact; and insurance information.

Why are insurance referrals and authorizations important?

Based on your insurance coverage and the services provided, an authorization or referral form from your insurance carrier may be required. It is important that you are familiar with your benefits and the extent of your medical coverage. We suggest that you contact your insurance carrier before scheduling a procedure.

What does it mean to be "out-of-network"?

Out-of-network refers to a patient seeking care outside the network of doctors, hospitals or other healthcare providers that the insurance company has contracted to provide care. It usually applies to health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Why do I have to verify my address each time I come in?

Though address and telephone numbers remain constant for approximately 70% of us, verifying this information is essential in our billing and collection processes.

Why do you need to re-enter my information each time?

Demographic information is considered valid for a certain period of time. Despite verifying the information, we still receive some mail each week with invalid addresses.

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Why must I show my insurance card each time?

Insurance coverage changes more frequently than addresses. Your card provides the pre-authorized telephone numbers, claims address and group numbers that are essential for us to process your insurance claim. As an industry standard, insurance information is considered accurate only at the time of service, thus the need for revalidation each time you are seen.

I have Medicare benefits which does not change. Why do I have to show my card every time?

Information contained on your Medicare card defines the correct billing expectation Medicare requires. While 99% of the time this does not change, our revalidation process requires that we renew the information in our system.

I am retired and have Medicare. Why do you ask about my and my spouse's employment status?

Medicare is a "last payer insurance." Federal law mandates that all Medicare providers verify at each visit that you or your spouse does not have an Employer Group Health Plan that would be primary over Medicare. When audited, we have to show proof that for each time you received services, you were asked specific questions relating to the possibility of other insurance. Additionally, if you are in an accident and someone else is at fault, the other party is responsible for your medical expenses according to federal law.

Why do I sometimes have to wait for medical tests because of an "order"?

Similar to a pharmacy filling a prescription, a physician's order must be on file requesting a diagnostic test before we can perform a service. If we do not have record of the order and it is not presented at the time of service, we must call the physician's office and request the order be faxed. The results are then directed to the ordering physician who will confer with you regarding the results.

What is a valid diagnosis?

All insurance companies require a valid diagnosis to enable them to determine the benefits due. It is the physician's responsibility to provide the hospital with a diagnosis. If you have questions concerning the diagnosis, you should contact you physician directly.

What can I do if a diagnosis code is not covered by my insurance?

Contact the physician's office and request submittal of a diagnosis change order to Singing River Health System Coding Department by faxing it to **228-809-2279**.

What is an Advance Beneficiary Notice, or ABN, for Medicare patients?

The ABN is a notice given to Medicare beneficiaries to keep patients informed that Medicare is unfortunately not likely to pay for various services. Per Medicare requirements, the provider must give the ABN to the patient before services are performed. The ABN will list the service, explain why Medicare might not pay, and inform you that you will be fully and personally responsible in the event that Medicare does not pay. After being informed that Medicare would not cover a test, if you choose to go ahead and have the service performed, you are accepting responsibility for payment of the service. If an order does not support the medical necessity at the time of the test, it will not be supported after the test.

For more information from Medicare on the ABN visit ***Medicare Advance Beneficiary Notice***.

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What are Co-payments, Deposits or other Coinsurance amounts?

This is an amount established by your insurance company as the patient's responsibility of billed fees. Co-pays, deposits and other co-insurance amounts are due at the time the services are provided. Depending on your insurance, you may be responsible for paying the entire charge and any charges for services not covered by your insurance. For a list of services that are not covered, please contact your insurance company.

When do I make the co-payment and/or deductible payment?

Co-payments are due at the time of service. If you are unsure of your co-pay responsibility, please consult your health insurance policy. Knowing your insurance policy is vital to receiving the maximum possible benefits. Failure to meet your insurance requirements can result in claim denial or a higher co-payment and/or deductible.

What payment options do I have?

Singing River Health System accepts personal checks and most major credit cards, including Master Card, Visa, American Express and Discover. When mailing in a payment, complete the information that is required on the remittance stub located at the bottom of your statement.
You may also pay your bill online at **singingriverhealthsystem.com**.
If you are unable to pay your entire balance at one time, you may request to set up a payment plan.
For more information, please contact Customer Service at **228-762-8876** or **1-800-552-3916**.

Why does my payment to the hospital go to Dallas, TX?

The hospital has a banking service which directs all payments made by our patients/customers to a special post office box called a lock box. This is similar to credit card payment debt where the bank retrieves, processes and deposits the funds on the same day to our local bank at a lower fee than what it would cost to process in-house.

What if I cannot pay?

Singing River Health System has ways to help our patients. If you need help, please call the hospital financial services office. Among the ways we can help are:

Hospital Financial Assistance: Singing River Health System provides free or reduced price care if you are a Jackson County resident and qualify based on your income. Financial assistance can help with hospital bills for inpatient or outpatient care. Our staff will help you find out if you qualify for financial assistance and help is offered to people with and without insurance.

Insurance Programs: Our staff can help you apply for public insurance programs such as Medicaid. This program may help you with your current bill and will help you pay for health needs in the future.

Payment Plans: If you need to pay your bill over time, our staff can help you set up an appropriate payment plan.

Do you offer a discount if I do not have insurance?

Yes, we extend a 60 percent discount to patients who are uninsured or to patients receiving services not covered by insurance.
This discount applies up to 30 days past your date of service.

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Do you provide pricing estimates?

As a service to our patients, we provide price estimates for many of the most commonly requested medical services and diagnostic tests performed at the hospital and its affiliates.

While we make every effort to ensure the accuracy of our price estimates, the costs associated with medical care and diagnostic testing can vary substantially, depending on each individual's medical needs and circumstances. We cannot determine in advance the exact total cost of a procedure because we cannot anticipate all of the charges that may be incurred in the course of treatment.

As a result, the final bill may be greater than or less than the estimate provided. Singing River Health System makes no guarantees regarding the accuracy of the pricing estimates and shall not be held liable for any inaccuracies.

What is not included in the estimate?

The estimates provided include only charges related to your hospital bill. Your physician and other physicians providing services related to your services will bill you separately. These physicians may include anesthesiologists, radiologists, pathologists and other specialists. Independent lab and radiology services – that is, ones not directly associated with Singing River Health System, but which may be used by your physician or other physicians who provide care to you – may also bill you separately. If you have questions about those bills, please call the telephone numbers on their statements for assistance.

The portion of your bill that is your responsibility is commonly referred to as your "out-of-pocket" expense. Out-of-pocket expenses are different for every patient and depend on individual insurance policies.

Why does hospital care cost so much?

The answer is complex. As with any business, hospitals must attempt to cover their expenses by charging for their services. But with hospitals, the cost of providing services includes many necessary and costly items that do not readily come to mind when most of us think about our care. We take it for granted that the hospital is there 24 hours a day, 7 days a week. Likewise, we have come to expect that hospitals will have all of the latest technology that could possibly be needed for our care. And we expect that the people caring for us are highly trained, highly skilled professionals. Finally, although we seldom think about it, the cost to collect from insurance companies, the under-insured, uninsured and indigent population increased demand of consumption of healthcare services contribute to the cost.

We, at Singing River Health System, regularly review our costs and pricing structure because we believe we must be a leader in getting healthcare costs under control, not only to support our customers' needs but also to improve upon the existing system of healthcare financing and delivery of care.

How does health insurance billing work?

As a courtesy to our patients, when you receive services at Singing River Health System, we bill your insurance carrier directly. In order to be sure the claim is properly submitted, we need a copy of your insurance card. HIPPA regulations require that we supply insurance providers complete information on the person that carries the coverage. This includes the name, address, phone number, date of birth and social security number. Incomplete information could mean a denial from your insurance provider. When your insurance provider delays, denies or makes partial payment, you are responsible for the balance. Any additional patient financial responsibility is due when you receive your statement. You may receive more than one statement for services rendered at Singing River Health System. These statements may be from a physician, or an ambulance service.

If you receive a hospital statement and do not understand the content, or if you believe that the information may be incorrect, please call our Customer Service Department at **228-762-8876** or toll-free **1-800-552-3916**.

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When should I expect to receive a statement?

Insurance claims are billed by Singing River Health System on a daily basis and typically processed by insurance carriers with 30-60 days. After the insurance carrier processes the claim, a statement for any patient/guarantor responsibility will be billed to you. If your insurance carrier requires additional information or denies the initial claim, an appeal process may delay your billing.

I have insurance. Why did I get a bill?

As a courtesy to you, Singing River Health System bills your insurance carrier directly for services rendered. The charges become your responsibility if your insurance carrier does not make payment. It is important that you provide accurate insurance information at the time of your appointment.

Why did I receive a bill from a doctor I did not see?

Hospitals often consult with specialized doctors as part of caring for patients. Often these specialists are sent items such as lab tests or X-rays for their expert review.

What if my hospitalization is the result of an accident?

If you had a non-work related accident, we will ask you for information about other insurance, like car insurance. If your accident or illness is work-related, we will bill your employer's workers' compensation program. It is important that you fill out the necessary paperwork, or you could be responsible for the balance.

Why can't I inquire about a statement if I am not the patient or guarantor?

Due to the HIPPA Privacy Act, we are only allowed to discuss account information with the patient or guarantor.

Did my insurance carrier pay for services?

Any payment made by your insurance carrier will be reflected on your statement. In addition, your insurance carrier will send an explanation of benefits (EOB) that details how your medical claim was processed and paid.

Why didn't my insurance carrier pay for the services?

If your claim is denied, you should contact your insurance carrier directly for an explanation about how your claim was processed.

Why am I getting a bill now, when services were provided so long ago?

Singing River Health System will process and send a bill to a patient after payment is received from the insurance carrier and it is confirmed that the balance is owed by the patient. The length of this process depends on how long it takes to receive a response from your insurance carrier.

Why do I continue to receive bills?

A new account is created for each date of service and the bill may be for a different date of service. Also, your payment may not have posted to your account before the next statement was generated and mailed. To determine if there is a balance, contact Customer Service toll-free at or **228-762-8876** or toll-free **1-800-552-3916**.

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My insurance should have paid my bill. What should I do?

Please verify that your insurance carrier has received and processed the claim. If the claim has not been processed, then carefully review your insurance policy or contact your insurance carrier to determine if the services and procedures are covered. Your insurance carrier will have the most accurate and up-to-date information about your policy and your claim. If your insurance company has questions, please direct them to contact Customer Service to verify that the most up-to-date insurance information is on file.

My insurance coverage has changed. What should I do?

To ensure prompt payment of your claim, please ensure we have your most up-to-date insurance information. Always take your insurance card with you to your appointments and make sure your health care providers have your current insurance information. If your insurance information has changed, you may call us or complete the change of information form located on the back of your statement and mail back to us.

What is a hospital-based clinic and will I have to pay more?

Singing River Health System has designated certain clinics as a hospital-based clinic. A hospital-based clinic is a facility similar to a physician's office. The clinic provides diagnostic, preventive, curative and rehabilitation services. The services are provided by an employed physician; however, the clinic is owned and operated by the hospital. Some insurance companies view this type of service as an outpatient clinic visit. You may incur a facility charge that may be assigned as a patient's co-payment responsibility. This kind of charge may not typically be incurred if the clinic were not considered hospital-based.

Billing Glossary

We realize that families and patients are not always familiar with healthcare terminology. We have provided a list of commonly used terms and their definitions to help assist you through the billing process.

Birthday Rules

Used to determine coordination of benefits (primary or secondary) for children. Insurances only use the month and day to determine coverage. We have listed some examples:

- Parents are married, the insurance of the parent whose birthday occurs first in a calendar year is primary, while the other parent's coverage would be secondary.
- If the parents have the same birthday, the parent who has had their insurance plan the longest would be considered primary.
- In situations where the parents are separated or divorced and both parents have coverage for the child, the benefits are determined in the following order.*
    1. The insurance plan of the parent with legal custody of the child.
    2. The plan of the spouse of the parent with legal custody of the child.
    3. Lastly, the plan of the parent who does not have legal custody of the child.
    4. *This can vary depending on the court decree, if there are no specific terms on a court decree, the benefit determination would be the same as the first bullet listed above.

Coordination of Benefits (COB)

An insurance group policy provision which determines the primary carrier, when the insured is covered by more than one plan.

Contractual Adjustment

The difference between the insurance contracted payment amount and the amount of the charge.

Co-payment or Co-insurance

A fee predetermined by your insurance policy that you pay for health care services.

Deductible

The amount of money a patient must pay for health care services before an insurance company will make a payment. This amount is predetermined by your insurance company based on your policy and usually due every calendar year.

EOB or Explanation of Benefits

Explanation of payments sent to the provider and policyholder by the insurance company.

Guarantor

The person financially responsible for the bill.

Managed Care

A medical delivery system (Medical Group) that manages the quality and cost of medical services.

Medicare

A federal insurance program which primarily serves those over 65 years or disabled people. Medicare is made up of two component, Part A and Part B.

Medicare Part A - covers inpatient hospital services, nursing home care, home health care and hospice care.

Medicare Part B - covers doctors' services, outpatient's hospital services, durable medical equipment and supplies and other health care services.

Visit the Medicare website for more information.

Non-Covered Services

Services an insurance policy does not cover. A patient incurs these charges.

Payment Arrangements

A payment plan formally set with either the financial counselor or customer service department, when the balance due on account cannot be paid in full. These plans are based on established policies and guidelines.

Payer or Payor

A third party entity (commercial/government) that processes and applies payment for your medical claim.

Prior-Authorization/Pre-Certification

A formal approval obtained to provide referred or requested services, granted by one or more of the following:

1. ***Health Plan*** - Medical Group or the hospital depending upon whom is financially responsible for the requested or referred services.
2. ***Referral*** - A physician's medical request for services or consultation to be provided by a specialist.
3. ***Self-Pay*** - An account for medical services, payable by the guarantor, when they do not have insurance coverage, the charges are non-covered and/or excluded from their policy.
4. ***Subscriber*** - A person who is enrolled for benefits with an insurance company
5. ***Workers Compensation*** - Insurance coverage provided by employers to cover employees injured on the job.