BILLING AND COLLECTIONS POLICY SUMMARY

CODING:

All charges are coded in accordance with provider documentation and in accordance with ICD-10 coding.

BILLING PROCESSES:

1. We can file to medical health insurance on behalf of our patients if the following are met:
    a. **GRHS will file medical health insurance if the following are met:**
        i. If this is not done at the time of service – the guarantor has 45 days to provide this information.
        ii. If insurance is not provided by the 45 day deadline, the full balance could become the responsibility of the guarantor.
    b. We must have a signed AOB (Assignment of Benefits) or COT (Conditions of Treatment) form on file. In some cases, insurance cannot be billed without the signed form.
        i. Document not signed at time of service - 2 attempts are made to acquire the signed document. If the document is not obtained the balance could become the responsibility of the guarantor.

STATEMENTS:

1. Statements are issued when the balance is identified to be the responsibility of the guarantor.
    a. Guarantor:
        i. Patient under the age of 18 –guarantor is the parent who was present at the time of service. **The Health System does not take into consideration divorce decrees or other legal documentation regarding custody or parental responsibility in relation to children.**
        ii. Patient over the age of 18 –they are their own guarantor unless they are considered a dependent of someone else
        iii. Spouse – a spouse is the guarantor of a deceased spouse's balances
        iv. Other – anyone other than those listed above in cases of 3rd party liabilities or Workers Compensation.
    b. Statements are issued every 30 days. The first statement is itemized. All additional statements are balance forward statements.

DISCOUNTS:

1. Financial Assistance – a completed application is required. Discounts based on Federal Poverty Levels. See the Financial Assistance policy for more details.

PAYMENT PLANS:

1. Payment in full is required at the end of the 12th month from the date of the first statement.
    a. Payment plans:
        i. Balances of $300 or less – $25 minimum monthly payment or the balance divided by the number of months available for a payment plan from the first statement date.
        ii. Balances over $300 – balance divided by number of months available for a payment plan from the first statement date.
2. Balance not paid in full at end of 12th month:
    a. Patient will use other resources available to pay balance in full.
    b. The balance could be turned to an outside collection agency. This INCLUDES accounts that are being paid on but not meeting the above required payment terms.

OTHER PATIENT RESOURCES:

1. Medical Expense Loan program. Brochure available upon request.
2. Financial Assistance. See Financial Assistance Policy.

TURNED TO OUTSIDE COLLECTION AGENCY:

1. Balance with no payments – will be turned to an outside collection agency after 120 days from the first statement date.
    a. This includes balances where insurance was not provided in a timely manner.
2. Payments being made – payments are less than acceptable per terms listed above and balance is not paid in full at the end of the 12th month. These will be turned to an outside collection agency after the 12th month.