

■ **GIVE**
“A PROMISE OF HOPE”

■ **Donate a Clever**
“Promise of Hope”

- Appreciated stock that you have owned for at least a year.
- Frequent-flier miles and similar perks from credit cards or other rebate programs.
- A gift for a child from a child - help your children or grandchildren pick out a stuffed animal or toy to give to a child in the hospital.
- Time – Volunteer for Patient Advocate Foundation.

Become a Partner in Progress with a Monetary “Promise of Hope”

- Donate a tax-deductible contribution In Memory of or In Honor of someone special.
- Encourage the company or organization you are employed with to match your contribution.
- Consider making a donation even if you don’t have cash, using your VISA or MasterCard.
- Remember Patient Advocate Foundation in your estate.

Patient Advocate Foundation

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A Greater Understanding

Interpreting Your Explanation of Benefits (EOB)



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A Greater Understanding

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■ MISSION STATEMENT

Patient Advocate Foundation is a national non-profit organization that serves as an active liaison between the patient and their insurer, employer and/or creditors to resolve insurance, job retention and/or debt crisis matters relative to their diagnosis through case managers, doctors and attorneys. Patient Advocate Foundation seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability.

Editors Note:

This is the third in the series “A Greater Understanding” brochures developed by the Patient Advocate Foundation. The information contained herein is in response to frequently asked questions (FAQ’s) by patients. This brochure is intended to provide a general yet informative response to these inquires. Any incident, inquiry or issue may vary according to these specific facts and circumstances relating to the individual.

Patient Advocate Foundation

■ PUBLICATIONS

- *The Managed Care Answer Guide*
Available in English & Spanish
- *The Patient Pal*
Available in English & Spanish
- *Your Guide to the Appeal Process*
Available in English & Spanish
- *First My Illness...Now Job Discrimination: Steps to Resolution*
Available in English & Spanish
- *Your Guide to the Disability Process*
Available in English & Spanish
- *The National Financial Resource Guide for Patients: A State-By-State Directory*
- *Too Young To Be Ill...*
A Practical Survival Guide for Caregivers of Children and Young Adults
- *Guide to Health Savings Accounts*
- *Promoting a Healthier African American community*
- *Promoting a Healthier American Indian and Alaska Native Community*
- *“A Greater Understanding” series*
A series of pamphlets written to provide answers to the most frequently asked questions regarding health care.

If you would like further information about any of these publications, please contact our office or visit our website: www.patientadvocate.org

Most of us have seen an “Explanation of Benefits” or EOB, but what does it mean?

After you’ve visited a doctor, clinic, or hospital, an EOB from the insurance administrator tells you and your provider what portion of the provider’s charges are eligible for benefits under your insurance plan.

The EOB is the result of the **claims process**. To better understand your EOB, let’s look at the steps in the claims process.

■ If your provider is part of a provider network, and you have an insurance plan using this network, the provider usually sends your bill to the network to have the network discount calculated. The network sends the claim to your insurance administrator.

■ If your provider is not in a network, the provider may send the bill to you or your insurance company. If you’re sent the bill, you will submit the claim to your insurance administrator.

■ Your insurance administrator reviews the claim to determine your benefits. If another insurance company is involved, the insurance companies coordinate the benefits to determine which plan is responsible for the charges. Your health administrator sends you and your provider an EOB, and, when appropriate, your provider also receives a check. Your EOB may identify:

- The patient and the service provided.
- The amount charged by the provider.
- The amount of the charges that *are covered* and *not covered* under your plan.
- The amount paid to your provider.
- The amount you’re responsible for.

■ **Remember that the EOB is not a bill**, but it explains what was covered by insurance. The provider may bill you separately for any charges you’re responsible for.

Below is an example of an EOB. Each section of the EOB has a number shown in parenthesis that corresponds to the following explanations for each section.

- (1) **Enrollee Name:** Identifies the policyholder. This is usually the name of the person who carries the insurance.
- (2) **Patient:** Identifies the patient.
- (3) **Patient #:** This serves as an identification number for the patient.
- (4) **Provider Name:** Identifies the name of the doctor or hospital that is billing for the services. Verify services were actually rendered by the provider listed.
- (5) **Claim #:** This is a number assigned to the claim by the insurance company to identify the claim in their computer system.
- (6) **Date Processed:** Indicates the date on which the claim was processed.
- (7) **Enrollee Address:** Indicates the address of the enrollee; this should be verified with each claim. A wrong address can cause problems in claims payment.
- (8) **Date of Service:** Indicates the date of when the service was rendered.
- (9) **Place of Service:** Indicates the location the service was rendered. This is important as some services are only covered in specific locations.
- (10) **CPT Code:** This identifies the service performed. This code is universal and cites the payment allowances.
- (11) **Charge Amount:** Amount charged by provider of service.
- (12) **Allowed Amount:** Amount allowed for the service is determined by a preset schedule of “usual and customary” (UCR) charges. Amount is usually determined

by geographic location of provider. For more information, please request the *Greater Understanding Series on UCR Charges*.

(13) **Not Covered:** Amount not included in the *allowed amount*; usually this is the amount deemed over the usual and customary allowance. In most incidences, the patient is responsible for the overage.

(14) **Reason Code:** This is an explanation of why a service was denied, or why an amount is not covered.*

(15) **Deductible:** This reflects the amount the patient must pay prior to having the benefits paid. Amounts that are *not covered* are not applied to the deductible. Generally, each patient will have his or own deductible to meet.

Deductibles may be required for both participating and non-participating providers; refer to the schedule of benefits.

(16) **Co-Pay:** A minimal amount required from the patient when seeking services from a provider. Usually the patient is responsible for co-payments only at a

participating provider.

(17) **Benefit Amount:** This is the percentage at which the *amount covered* will be paid. The percentage paid will be determined by the schedule of benefits. Generally, participating providers will be paid a higher level; non-participating providers will be paid a lower level.

(18) **Due from Patient:** This is the amount the patient is responsible for paying to the provider. This generally includes the co-pay amount, deductible and may or may not include the amount over the UCR. If the amount over the UCR is not included, the patient needs to verify if the provider of service will write the amount off. If the provider of service will not write the amount off, the patient is responsible.

(19) **Payment Amount:** This is the amount paid to the provider.

(20) **Customer Service:** This is the number used to contact the customer service for your insurance.

Your Health Insurance
P.O. Box 1999
Anytown, USA 12345

(20) Customer Service 800-555-1212

(1) Enrollee: John Doe
(2) Patient: Jane Doe
(3) Patient #: 123-45-6789
(7) Enrollee Address: 555 Main Street
Hometown, USA 54321

This is Not a Bill

(4) Provider Name: Mark Smith, M.D.
(5) Claim #: 99999999999
(6) Date Processed: 9/25/02

(8) Dates of Service	(9) Place of Service	(10) CPT Code	(11) Charge Amount	(12) Allowed Amount	(13) Not Covered	(14) Reason Code	(15) Deductible Amount	(16) Co-Pay	(17) Benefit Amount	(18) Due from Patient	(19) Payment Amount
8/9/02 8/9/02	3	99201	80.00	80.00				15.00		15.00	
8/9/02 8/9/02	3	10121-22	150.00		150.00	55			0.00	0.00	0.00
8/9/02 8/9/02	3	36415	20.00	10.00	10.00	44			80%	2.00	8.00
8/9/02 8/9/02	3	80050	40.00	10.00	30.00	44			80%	2.00	8.00

*These codes are explained in foot notes on the EOB.