Zohaibcare Plus Healthcare Clinic

Insurance Coverage Guide

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1. ACCEPTED INSURANCE PLANS

1.1 Major Commercial Insurance

Fully Accepted Plans:

- **Aetna:** All plans including HMO, PPO, EPO, and HDHP
- **Anthem Blue Cross Blue Shield:** All product lines
- **Cigna:** All plans including Connect and HealthSpring
- **Humana:** All commercial plans and Medicare Advantage
- **United Healthcare:** All plans including UMR and Oxford
- **Kaiser Permanente:** Out-of-network coverage only

Copayment Structure:

- Office visits: $15-$40 depending on plan
- Specialist referrals: $25-$60
- Urgent care visits: $50-$100
- Annual physical exams: Usually covered 100%

1.2 Government Insurance Programs

Medicare:

- **Original Medicare (Parts A & B):** Fully participating provider
- **Medicare Advantage:** Contracted with 18 local MA plans
- **Medicare Supplement:** All plans accepted
- **Medicare Part D:** Prescription coverage coordination available

Medicaid/State Programs:

- **State Medicaid:** Full provider for all plans
- **Managed Care Organizations:** Contracted with 6 local MCOs
- **CHIP (Children's Health Insurance):** Participating provider
- **Emergency Medicaid:** Accepted for qualifying services

1.3 Specialty Insurance Plans

Workers' Compensation:

- All state-approved carriers accepted
- Direct billing available
- Pre-authorization assistance provided
- Return-to-work evaluations available

Auto Insurance (Personal Injury Protection):

- Medical payments coverage accepted
- PIP claims processed
- Coordination with legal representatives
- IME (Independent Medical Examinations) available

2. COVERAGE DETAILS BY SERVICE TYPE

2.1 Preventive Care Services

100% Covered Services (No copay/deductible):

- Annual physical examinations
- Well-woman exams
- Mammography screening
- Colonoscopy screening
- Immunizations (flu, pneumonia, Tdap)
- Blood pressure checks
- Cholesterol screening
- Diabetes screening

Age-Specific Preventive Services:

- **Children (0-18):** Well-child visits, immunizations, developmental screenings
- **Adults (18-64):** Annual physicals, cancer screenings, cardiovascular assessments
- **Seniors (65+):** Medicare Annual Wellness Visits, fall risk assessments

2.2 Diagnostic Services

Laboratory Testing:

- **Covered:** CBC, basic metabolic panels, lipid testing, HbA1c, thyroid function
- **Typical copay:** $10-$25 for routine tests
- **High-deductible plans:** Subject to deductible until met

Imaging Services:

- **X-rays:** Usually covered with $50-$100 copay
- **Referral required:** MRI, CT scans, ultrasounds
- **Prior authorization:** Often required for advanced imaging

Cardiac Testing:

- **EKG:** Covered with office visit
- **Stress testing:** Requires prior authorization
- **Echocardiogram:** Specialist referral typically required

2.3 Treatment Services

Minor Procedures:

- **Skin lesion removal:** Covered with copay
- **Wound care:** Included in office visit fee
- **Joint injections:** May require prior authorization
- **Suture removal:** Usually no additional charge if done at our clinic

Chronic Disease Management:

- **Diabetes care:** Covered including supplies and education
- **Hypertension management:** Routine visits covered
- **Asthma care:** Includes medication management and monitoring

3. PRIOR AUTHORIZATION REQUIREMENTS

3.1 Services Requiring Pre-Authorization

Always Required:

- MRI and CT scans
- Sleep studies
- Specialist referrals (HMO plans)

- Physical therapy (>6 visits)
- Durable medical equipment
- Home health services

Sometimes Required (Plan-Dependent):

- Laboratory tests >$500
- Cardiac procedures
- Pain management referrals
- Mental health services
- Dermatology procedures

3.2 Authorization Process

Timeline:

- **Urgent requests:** 24-48 hours
- **Routine requests:** 3-5 business days
- **Complex cases:** Up to 14 days

Required Information:

- Clinical documentation
- Medical necessity justification
- Previous treatment attempts
- Diagnostic test results
- Provider recommendations

Our Support:

- Dedicated authorization specialist
- Appeals assistance
- Direct insurance company communication
- Status updates provided to patients

4. PAYMENT STRUCTURES AND COPAYS

4.1 Common Copayment Structures

HMO Plans:

- Primary care visits: $15-$25
- Specialist visits: $30-$50
- Urgent care: $75-$100
- Emergency room: $150-$300

PPO Plans:

- In-network primary care: $25-$40
- Out-of-network: 70% coverage after deductible
- Annual deductibles: $500-$5,000
- Out-of-pocket maximums: $2,000-$8,000

High-Deductible Health Plans (HDHP):

- High deductibles: $1,500-$7,000
- Lower premiums
- HSA-compatible
- 100% coverage after deductible met

4.2 Special Populations

Medicare Beneficiaries:

- **Part B deductible (2025):** $240 annually
- **Standard coinsurance:** 20% after deductible
- **Medicare Advantage:** Varies by plan
- **Medigap coverage:** Supplements Original Medicare

Medicaid Recipients:

- **Copays:** $0-$5 for most services
- **No deductibles:** Most services covered in full
- **Prior authorization:** Required for some services
- **Emergency services:** Always covered

5. COVERAGE VERIFICATION PROCESS

5.1 Pre-Visit Verification

Information Collected:

- Insurance carrier and plan type
- Member ID and group number
- Effective dates of coverage
- Copayment amounts
- Deductible status
- Prior authorization requirements

Verification Timeline:

- **New patients:** 48 hours before appointment
- **Established patients:** Annually or with insurance changes
- **Urgent visits:** Real-time verification when possible

5.2 Benefits Explanation

Covered Services:

- Office visits and procedures
- Laboratory and diagnostic tests
- Preventive care services
- Specialist referrals
- Prescription coverage

Patient Responsibility:

- Copayments due at time of service
- Deductible amounts
- Coinsurance percentages
- Out-of-network charges
- Non-covered services

6. BILLING AND CLAIMS PROCESS

6.1 Claims Submission

Electronic Claims:

- Submitted within 24 hours of service
- Real-time eligibility checking

- Automated denial management
- Electronic remittance advice

Claim Follow-up:

- **Initial submission:** Within 24 hours
- **Follow-up on denials:** Within 5 business days
- **Appeals process:** Initiated within 30 days
- **Patient notification:** For any coverage issues

6.2 Patient Billing

Billing Cycle:

- Statements mailed monthly
- Online billing available through patient portal
- Payment plans available for balances >$500
- Multiple payment methods accepted

Financial Assistance:

- Sliding fee scale for uninsured patients
- Payment plans up to 12 months
- Charity care program available
- Community resource referrals

7. SPECIAL PROGRAMS AND DISCOUNTS

7.1 Uninsured Patient Discounts

Self-Pay Discount: 30% off standard charges **Prompt Pay Discount:** Additional 10% if paid within 30 days **Preventive Care Package:** Annual physical + basic labs for $200 **Senior Citizen Discount:** 15% off for patients 65+ without insurance

7.2 Wellness Programs

Covered Wellness Services:

- Smoking cessation programs
- Weight management counseling
- Diabetes education classes
- Blood pressure monitoring programs

- Flu shot clinics

Partnership Programs:

- Local gym membership discounts
- Nutritionist consultations
- Health screenings at community events
- Corporate wellness contracts

8. FREQUENTLY ASKED QUESTIONS

Q: What happens if my insurance denies a claim?

A: We will appeal denied claims on your behalf and keep you informed throughout the process. You won't be billed until all appeal options are exhausted.

Q: Can I see a specialist without a referral?

A: It depends on your plan. HMO plans require referrals, while PPO plans typically allow direct access to specialists, though you may pay more.

Q: What if I don't have my insurance card?

A: We can verify coverage using your name, date of birth, and social security number. However, having your card ensures accurate billing.

Q: How do I know if a service requires prior authorization?

A: Our staff will verify this when scheduling your appointment and obtain any necessary authorizations before your visit.

Q: What happens if I need emergency care?

A: Emergency services are covered by all plans. Go to the nearest emergency room if you have a true medical emergency.

9. CONTACT INFORMATION

Insurance Verification:

- **Phone:** (555) 123-4568
- **Email:** insurance@medicareplus.com
- **Hours:** Monday-Friday, 8:00 AM - 5:00 PM

Billing Questions:

- **Phone:** (555) 123-4569

- **Email:** billing@medicareplus.com
- **Online:** Patient portal billing section

Financial Assistance:

- **Financial Counselor:** Sarah Johnson
- **Phone:** (555) 123-4570
- **Email:** financial@medicareplus.com

Prior Authorization Help:

- **Authorization Specialist:** Mike Chen
- **Phone:** (555) 123-4571
- **Fax:** (555) 123-4572

10. INSURANCE UPDATES AND CHANGES

Annual Open Enrollment Reminders:

- **Medicare:** October 15 - December 7
- **Marketplace plans:** November 1 - January 15
- **Employer plans:** Varies by company

Mid-Year Changes Allowed For:

- Job loss or gain
- Marriage or divorce
- Birth or adoption of child
- Loss of other coverage
- Moving to new area

Important Notice: Insurance benefits and coverage can change frequently. This guide provides general information, but specific coverage details should always be verified with your insurance company or our verification staff before receiving services.