Registration and billing

Main Line Health®

Well ahead.®

Welcome to Main Line Health®

Thank you for choosing Main Line Health for your health care. We want to make your experience with us as pleasant as possible. This brochure has been prepared to answer many common questions that our patients have about registration and billing for our services. We believe it is important that you understand Main Line Health's billing policies and the payment options available to you as a patient.

Main Line Health is committed to treating patients with emergency medical conditions regardless of their ability to pay. An emergency medical condition is defined by the Emergency Medical Treatment and Labor Act (EMTALA), which was enacted in 1986 under Section 1867 of the Social Security Act. Based on EMTALA, an emergency medical condition is an acute medical condition that, if not given immediate medical attention, could reasonably be expected to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part. With respect to a pregnant woman having contractions, an emergency medical condition means that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child.

Main Line Health is committed to providing Charity Care and Financial Assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Main Line Health is committed to treating patients who have financial needs with the same dignity and consideration that is extended to all its patients.

Our billing policies are outlined in this brochure. Key definitions and contact numbers are listed for your convenience. Further information, including frequently asked questions and additional definitions, can be found online at mainlinehealth.org/patientbilling.

Registration services

1. Check in

When you go to a Main Line Health facility for care, the admitting office or registration department gathers information about you, and/or the person responsible for paying for the services (the guarantor) and the insurance organization that will be billed. You will be asked to provide:

- Demographic information: name, address, phone number, race, ethnic background and Social Security number (required by the state of Pennsylvania Healthcare Cost Containment Council)
- Insurance card
- Photo identification

You also will be asked to provide:

- A signed prescription or order from your physician, including diagnosis code(s)
- A referral and/or pre-certification number (if required by your insurance carrier) which should be provided by your physician's office

2. Documents

You will be asked to sign several documents, including:

- Acknowledgment that you have received a Notice of Privacy Practices
- Consent to treatment and financial obligations
- Medicare Secondary Payer (MSP) questionnaire (Medicare beneficiaries)
- Advanced Beneficiary Notice (some Medicare beneficiaries): advises you that the test/procedures performed may not be covered by Medicare. The purpose of the Advanced Beneficiary Notice is to let you know in advance that these services may not be covered and to advise you that you will be responsible for the Medicare reimbursement rate for these charges.

3. Advance directive

You are also asked about an advance directive when you register for inpatient or outpatient hospital services. Formal advance directives are documents written in advance of treatment or serious illness that state your choices for health care, or name someone to make those choices, if you become unable to make decisions. Medicare and hospital-accrediting bodies (organizations that oversee the quality of care provided by hospitals) require we ask each patient, at each visit, whether or not the patient has a current advance directive. This could be in the form of a living will, health care power of attorney, or both. Through these documents you can make legally valid decisions about your future medical treatment. Find out more and download our advance care planning guide at mainlinehealth.org/acp.

4. Payment at time of service

Most Insurance plans require that you pay a copayment, co-insurance and/or a deductible for your health care services (patient responsibility). In some instances, your insurance carrier may require a pre-certification for certain outpatient services that have been prescribed for you. This is the physician's responsibility to obtain from your insurance company. If your physician has not obtained a pre-certification, your test or procedure may be canceled or delayed.

Main Line Health representatives will present you with an estimate of your copayment, co-insurance and/or deducible based on our understanding of your individual insurance coverage. It is our expectation that this copayment, co-insurance, or deductible be made at time of service.

For your convenience we accept cash, check, Visa, MasterCard, American Express and Discover cards.

5. A special note to new and expecting parents

Most insurance companies require that a new child be added to the parent's policy within 30 days of birth. Failure to do so could result in non-payment for the child's hospital services by the insurance company. If this occurs, the parent/responsible party will be billed for the services. Please check with your insurance company to determine when they require a new child to be added to the policy.

Charity care and financial assistance

Main Line Health is committed to providing charity care and financial assistance to persons who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergency or other medically necessary care based on their individual financial situation. Main Line Health is committed to treating patients who have financial needs with the same dignity and consideration that is extended to all patients. Main Line Health intends, with this policy, to establish financial assistance procedures that are compliant with applicable federal, state and local laws. This policy covers medically necessary health care services provided by Main Line Health, including employed Main Line HealthCare providers. Physicians covered by this policy are listed in Schedule D of the Main Line Health Charity Care and Financial Assistance Policy located at mainlinehealth.org/charitycare. Any person who does not have insurance or does not have the ability to pay all or part of their financial responsibility to Main Line Health for Main Line Health provided services may apply for charity care and financial assistance.

- **Charity care:** Patients with income 300 percent below the federal poverty level will be eligible for 100 percent charity care.

- **Financial assistance:** Patients with income in excess of 300 percent, but not exceeding 500 percent, of the federal poverty level, will be responsible for amounts generally billed (AGB). AGB refers to the amount generally billed by the hospital to insurers. Patients eligible for financial assistance will not be billed more than what Main Line Health would receive if the patient were a Medicare beneficiary.

Patients applying for charity care or financial assistance must complete an application. Main Line Health staff will review and determine if the application is complete and whether the documentation supports the patient's eligibility for charity care or financial assistance.

You may obtain or request a free copy of the Main Line Health Charity Care and Financial Assistance Policy and application from patient registration staff, at mainlinehealth.org/charitycare, or call 484.580.4360. The policy is also available in Spanish.

Our billing policies

Main Line Health patient bills reflect our efforts to provide the highest quality care possible in the most cost-efficient manner. Our commitment—to deliver advanced medicine to treat and cure disease while also playing an important role in prevention and disease management as well as training physicians and other health care providers—reflects our intent to keep our community and ourselves well ahead.

We want to help patients understand how we handle billing and what their financial responsibilities are as a patient. We aim to provide patients with information, counseling and options necessary to make this process as smooth and simple as possible.

The hospital bill is based on the type of service you receive. The amount you owe may include insurance deductibles, non-covered services or charges, as well as copayments, co-insurance, or other balances that may be due after the insurance has paid on a charge.

We will file a claim with your insurance carrier. For certain types of insurance coverage, if there is a balance due after your insurance company has processed your claim, or if you do not have insurance, we will mail a billing statement to you. We will not bill you for such balances unless permitted under your health plan and applicable law.

In addition to the hospital billing statement, you may receive bills from one or more other care providers for professional services. These providers will send you separate bills for their fees when their services are not covered by the hospital bill. Such providers may include:

- The hospital-based physician(s) who cared for you while you were a patient at the hospital
- The anesthesiologist if you had a procedure at the hospital
- The ambulance company if you were brought to the hospital by an ambulance
- Physicians whom you may not have seen but who may have provided interpretation services for lab work and X-rays

Payment policy

Patients are financially responsible for the charges for services received. Any unpaid balances, including copayments, deductibles and non-covered services, are your responsibility. Such balances must be paid at the time of service or upon receipt of your billing statement.

Main Line Health assists patients in meeting their financial obligations by:

- Filing insurance claims, as long as a valid insurance identification card and/or complete insurance information is provided at the time of registration.
- Allowing your insurance carrier a reasonable time to make payment.
- Providing patients with a bill for balances after the insurance has paid.
- Providing patients with itemized bills upon request.
- Accepting a variety of payment methods including: cash, check, electronic bank checks, Visa, MasterCard, American Express, and Discover.
- Appealing insurance denials whenever appropriate and possible.
- Assisting patients who are unable to make payment in full with monthly payment options. Payment terms are set based on your account balance. Payment arrangements, other than payment in full, must be approved in order to keep your account from being considered past due. Monthly payment plans may be arranged by calling Main Line Health customer service at: 484.580.4360.
- Screening patients for Pennsylvania Medical Assistance. Any person who does not have insurance or does not have the ability to pay all or part of their financial responsibility to Main Line Health may apply for charity care and financial assistance.

Main Line Health follows established guidelines for collecting outstanding patient balances. Patients receive a series of letters and phone calls until your responsibility amount is paid in full. Our guidelines for collecting accounts allow for delinquent accounts to be placed for recovery with a professional collection agency or attorney.

Refunds

We carefully research all patient overpayments to ensure that patient refunds are appropriately due. We process patient refunds weekly.

Registration and billing terminology

Advanced Beneficiary Notice (ABN):
A form advising you that the test/procedures performed may not be covered by Medicare. The purpose of the ABN is to let you know in advance that these services may not be covered and to advise you that you may be responsible for payment of these related charges. An ABN gives you the option to accept or refuse the items or services in cases where Medicare denies payment.

Benefit:
A general term referring to any service (such as an office visit, laboratory test, surgical procedure) or supply (such as prescription drugs, durable medical equipment) covered by a health insurance plan in the normal course of a patient's health care.

Birthday rule:
Generally, the method used by health insurance companies to determine which parent's health insurance coverage will be primary for a dependent child, when both parents have separate coverage. Typically, the health insurance plan of the parent whose birthday falls earliest in the year will be considered primary.

COB (coordination of benefits):
This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy or other liability payer, such as for auto-related or work-related injuries.

Co-insurance:
A type of cost sharing where the patient or beneficiary (the insured) and insurance provider share payment of the approved charge for covered services. This is typically expressed in a specified ratio after payment of the deductible by the insured. For example, your policy may cover 80 percent of charges. Your co-insurance/patient portion would be the remaining 20 percent.

Copayment:
A fixed dollar amount set by the insurance company for the specific type of visit. This information can routinely be located on the insurance card and will be different according to the type of visit. For example, emergency room visit, inpatient stay, primary care physician (PCP) office visit, or specialist office visit.

Deductible:
A type of cost sharing where the patient, or beneficiary, pays a specified amount of approved charges for covered medical services before the insurer will pay for all or part of the remaining covered services. Usually the deductible needs to be met and paid by the patient each year.

Explanation of benefits (EOB):
This is a notice provided by your insurance company after your claim for health care services has been processed. It explains the amounts billed, paid, denied, discounted, and the amount owed by the patient. The EOB also may communicate information needed by the insured in order to process the claim. The EOB may be mailed to you or accessed on your insurance company's website.

Medicare Secondary Payer (MSP) questionnaire:
If you are a Medicare beneficiary, you will also be asked to complete an MSP questionnaire. Medicare pays for your care only after all other available insurance is exhausted. To determine whether or not you have any other source of insurance, Medicare requires a beneficiary to complete an MSP questionnaire for every admission, outpatient encounter or start of care. There are a few exceptions to this rule for lab services and recurring services like physical therapy.

Network:
A "network" plan is a variation on a PPO plan. With a network plan you'll need to get your medical care from doctors or hospitals in the insurance company's network if you want your claims paid at the highest level. Services rendered by out of network providers may not be covered or may be paid at a lower level.

Network provider:
A health care provider who has a contractual relationship with a health insurance company.

Pre-certification ("pre-cert") number:
A number obtained from your insurance company by doctors for certain tests and procedures. This number will represent the agreement by the insurance plan that the service has been approved. This is not a guarantee of payment. This authorization number will be required by Main Line Health at time of scheduling or time of registration.

Referral:
Most managed care plans, health maintenance organizations (HMOs), and point-of-service (POS) plans require that your primary care physician refer you to receive specialty care. Each plan is different and it is your responsibility to know the requirements for your plan and obtain any necessary referrals.

Main Line Health billing and physician group contacts

Main Line Health patient billing customer service:	**484.580.4360**
Main Line Emergency Medicine Associates, LLC:	**302.273.2247**
Radiology Associates of the Main Line:	**1.800.841.4236**
Main Line Health Imaging (MRI & PET/CT):	**1.800.800.1617**
Main Line Health Laboratories (mainlinehealth.org/mlhl):	**484.580.4100**
Main Line HealthCare (mainlinehealth.org/mlhc):	**484.565.1640**
United Anesthesia services:	**1.800.222.1442**
Main Line Pathology Associates:	**1.888.625.4685**
Riddle Ambulance services:	**484.227.4403**

Main Line Health is committed to providing a superior patient experience. Please let us know if we can answer any questions, by calling:

484.580.4360

Main Line Health®

Well ahead.®

Membership on the medical staff of Main Line Health hospitals does not constitute an employment or agency relationship.

MLH.12-18.LA.0774