INSURANCE INFORMATION

How do I find out how much my insurance company will pay towards my therapy services at Joy Miller & Associates?

The cost of therapy services can vary greatly depending upon your own individual insurance policy. Most insurance companies provide a policy handbook that outlines coverage. Your Human Resource Department should be able to explain your benefits in greater detail. If you have no HR department, then you will have to call your insurance company directly to find out more about your insurance benefits.

We always suggest that you contact your insurance company directly and ask them to quote your ***"mental health benefits for outpatient therapy."*** Most insurance companies have a customer service number listed on the back of your insurance card. Call this number and be sure to ask them the following questions: How many visits do I have per year? What is my co-payment? What is my deductable, and how much have I met this current year? Do you require pre-authorization, and if so can I do this now?

How do I get pre-certified for mental health treatment?

Most insurance companies simply require a phone call from you to pre-certify your benefits. This means that they assign an authorization number to you and that this approval number ***MUST BE SUBMITTED WITH THE CLAIM*** when mailed by our office. Please bring any pre-certification number to your first intake appointment at Joy Miller & Associates. On occasion, precertification may require a treatment plan submitted by your therapist. If this is necessary, your therapist will do this after the first intake appointment and submit it to your insurance company.

WARNING: If an insurance company requires pre-certification and this process is not done ***prior*** to the appointment, the insurance company will not pay for the claim. In this event the client is responsible for the full amount of the claim.

How do find out if my therapist is a preferred provider for my insurance company?

This question simply requires a phone call to the insurance customer service number. When you call the insurance company, simply ask if we are a preferred provider. The preferred provider status may be listed under Joy Miller & Associates and/or the individual therapist name, so check both. Some insurance companies have us listed as preferred providers under different areas of expertise so it is important to check both the group name and if needed, your individual therapist's name. Insurance companies often buy each other and have many complex contracts. As a result, this process can sometimes become very difficult. We are familiar with most of the insurance companies that we participate with, so we can help with this process.

My insurance company says you are not a preferred provider, what can I do to retain therapy services at Joy Miller & Associates?

Please contact us and we will explore becoming a provider for your specific insurance company, if possible. Our office manager can help with this procedure. Please note that we have had situations where an insurance company has said we are not on a provider list and they have been incorrect.

What is the difference between in-network and out-of-network benefits?

Some insurance companies require that providers join their network for insurance benefits to be applied at an "in-network" rate. In this case we are identified as preferred providers. For various reasons, we may have chosen not to join an insurance company panel for mental health treatment. One reason not to join a panel is when the insurance company offers better out-of-network benefits than in-network. Therefore, if you discover that we are not a preferred provider ask for a quote for out-of-network benefits. It may just have better benefits. In addition, an insurance company may "flex" their benefits to cover services at our office in certain circumstances.

I have HMO insurance; do I have to see my doctor first?

Almost all HMO insurance plans REQUIRE a direct referral from your primary care doctor prior to your initial appointment. Sometimes this is just a simple as making a phone call to your doctor, while with other HMO policies your doctor may require an office visit to generate the referral process. This requirement is often at your doctor's discretion.

WARNING: An insurance company will not pay out mental health benefits if an HMO referral is received by our office AFTER the therapy appointment.

Joy Miller & Associates
7617 N Villa Wood Lane
Peoria, IL 61614
309-693-8200
Fax: 309-693-8207
www.joymiller.com

Why is my co-pay higher than a typical doctor's visit?
Often mental health services fall under specialty services for insurance policies. As a result, their may be a higher co-payment and/or deductable to meet than a medical checkup.

When does JMA submit claims and how long does it take for insurance to pay on a claim?
Claims are routinely submitted on a daily basis. Insurance companies are required to respond to a claim with in 30 days. This does not necessarily mean that they pay the claim in 30 days. On average most claims are paid to our office within 2-4 weeks, but some claims have not been paid for over 90 days.
If an insurance company does not respond to a claim in 30 days, it is recommended that you to call your insurance company and follow up with them related to payment of your bill. Remember that you are ultimately responsible for the cost of services rendered.

What does primary and secondary insurance mean?
Primary insurance is the insurance company responsible for payment of benefits that are first applied. JMA will bill primary insurance but not secondary. We ask all of our clients to pay for services that are not covered by their primary insurance at the time of service. If you have secondary insurance we can explain how to submit claims to secondary insurance and provide you with the necessary forms and documentation.

Why don't you bill my secondary insurance?
As a courtesy we will bill your primary insurance. Due to the time and expense required to do billing, it is impossible for our office to handle more than one billing to an insurance company per client.

I have a one year pre-existing condition clause, what does this mean?
This means that the insurance company may deny benefits of Mental Health for the first year of the policy. We would strongly encourage you to make a phone call to the insurance company prior to benefits being used and see if they will be willing to make an exception.

My insurance is researching the claim for a pre-existing condition, what does this mean?
In our experience, this means the insurance company is very likely to deny the claim. The insurance will not pay on the claim until they are finished researching it. Typically, the insurance company requests additional information about the original claim and after this information is submitted they deny benefits. Sometimes claims are paid but it seems not be the norm.

Why do I have to make payments towards my deductable at the time of service?
JMA requires clients to pay at the time of service for any amount that the insurance company will not cover. If an insurance company reports that you have only met 100.00 towards a 250.00 deductable, you will be responsible for meeting the deductable with us at the time of rendered services, up to the cost of the appointment. We agree to wait on payment for services rendered in good faith for benefits that insurance companies quote.

My explanation of benefits (EOB) has denied a claim but they should have paid it. What should I do now?
Contact your insurance company and discuss this situation with them. Keep calling your insurance company and reminding them that you have benefits under your employment contract. If appropriate, use your human resources department for help with this issue, or speak to your HR department about handling this situation for you.
When a claim has been denied at Joy Miller & Associates the amount of the session becomes the responsibility of the client and is billed to the client.

My insurance company said they would pay more than they did. Why did this happen and am I responsible for the difference?
All insurance companies may pay benefits differently than they quote so it is important to review each claim carefully. Insurance companies typically state, when quoting benefits, that benefits may be applied differently when the claims are processed.

My insurance has changed, what can I do?
Call us ***immediately*** and supply us with your new insurance information. This will assure that claims are submitted to the correct insurance company and you do not receive a bill for service that may have been covered.

What happens if I have a huge bill that I did not expect?
Call us and speak with us about the situation. DO NOT AVOID THE ISSUE. We may be able to work with you. However, a delay in dealing with an outstanding balance can incur many potential negative consequences such as being submitted to collections and legal action.

Does my insurance company cover couples, marital or pre-marital therapy?
As a matter of record there can only be one client of record. All claims are billed under one insured name not two. Therefore, billing codes must be submitted either as a family session or as an individual session with one person being the identified patient and the other person being present during the session.