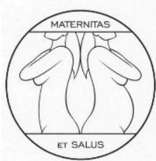

Women for Women

Obstetrical Payment Planning

For questions contact:

Billing: 309-888-9900 opt 5

We are happy and proud you have entrusted us with your medical care. We strive to provide premium medical care. We strive to help you understand the ever-changing insurance environment as well as payment at the time of service which is expected and contractually obligatory. Below you will find a brief explanation of some financial terms and conditions.

Upon request, *Women for Women* can provide you with an estimate for out of pocket cost for the services rendered/to be rendered to you during your prenatal, delivery, and immediate postpartum period, based on the information we get from your insurance company. This verification of benefits and estimate of out-of-pocket expenses is a courtesy provided by our office; all benefits are subject to eligibility, medical necessity, terms, conditions, and limitations of the policyholder's plan at the time of service. <u>It is ultimately your responsibility to know your plan benefits.</u> We will bill all participating insurance companies for the obstetric patient. Because of this, it is mandatory that you notify us of any change in insurance coverage. We do not accept Illinois Medicaid as a secondary insurance.

As described below, many commercial insurances pay at a certain level and almost all patients will have an out of pocket expense with the pregnancy and delivery.

Your prenatal and postpartum visits as well as the delivery are billed as a global package fee after you deliver (some exceptions apply). The global package includes the following. Any additional testing or procedures beyond these visits may be an additional charge. The global package is: an initial visit between 8 and 12 weeks. 1 visit every 4 weeks until approximately 28 weeks gestation. 1 visit every 2 weeks thereafter until approximately 36 weeks gestation. As well as 1 visit every week thereafter until delivery. Additional charges, such as ultrasounds, laboratory testing, and non-stress testing will be billed to your insurance company at the time of service. Any balance remaining from these tests will be sent to you, the patient, for payment. After the delivery of your baby/babies you will most likely receive invoices from the Hospital, Laboratory, Pediatrician and possibly us, because this is just an estimate. Please be assured that any overpayment will be reviewed and, if appropriate, a reimbursement will be issued.

CO-INSURANCE: Co-insurance is based on the predetermined level of coverage outlined in your insurance policy. Many commercial insurance companies pay on claims at a level of 80/20, meaning the insurance company will consider and pay on 80% of the charges and the remaining 20% is considered the patient's co-insurance. It is important that you review your insurance coverage to determine your level of co-insurance. If your insurance coverage only pays a percentage portion of your insurance claims, then you will be billed for any remaining balance-deductibles or co-insurance- determined by your insurance company, along with any amount that your insurance considers to be over the usual and customary fee.

Additionally, many insurance companies maintain a preferred provider network that allows for reduced co-insurance amounts with patients utilize in-network, preferred providers. It is the patient's responsibility to verify network participation prior to obtaining health care services. In the event that *Women for Women* has a preferred provider agreement with your insurance, any applicable write-offs will be taken prior to billing you for any remaining balance.

CO-PAYMENTS: Women for Women is a preferred provider with many third-party payers. Many of these insurers require a co-payment for office visits. If your insurance coverage requires a co-payment for office visits, you will be required to pay this at the time you check-in for your appointment.

SELF-PAY PATIENTS (no insurance): Patients without any valid insurance coverage will be required to pay for any charges at the time of service. A $600/month payment is expected from any self-pay pregnant patient; this amount will cover routine prenatal visits and routine vaginal delivery without complications. Any lab work, ultrasounds, and complication coverage will incur additional charges.

CODING FOR YOUR SERVICES: Many insurance companies have restrictions on the type of services that are covered by their policies. For example, preventive services may be excluded or limited to one preventative visit in a 12-month period, or problem related visits might be subject to a deductible, etc. It is the patient's responsibility to know the limitations of her particular insurance coverage. Women for Women cannot charge for services based on the limitations of your individual insurance policy. Government regulations dictate that all health care providers must submit claims that accurately reflect the services that are provided and documented in the patient's medical record. Please don't request our staff to bill services in a particular manner in an effort to enhance reimbursement by your insurance company. To maintain compliance with current government regulations and uphold the highest ethical standards, our staff is under strict guidelines that demand that they code services to the highest degree of accuracy.

Information about our office & pregnancy:

Communication

Feel free to ask questions or voice concerns during your visit. We welcome and encourage you to call the office for any medical problems or additional questions. Please make non-emergency calls during routine office hours. This allows the on-call provider to handle emergencies in a timely manner.

If an emergency arrives after business hours, please call the office at the above number and listen for the message instructions on how to reach the provider on call. No routine questions or medication refills will be handled at this time. Please also bear in mind that the care giver may be tied up in an emergency or delivery but will get back to you as soon as possible. If you feel you need to go to Labor and Delivery or the Emergency Room, please do so and the provider will be contacted by the facility at the time of your arrival.

Appointments

Please schedule appointments while checking out after your visit or by calling our office. If you have been advised of the need for an ultrasound or non-stress test please tell the receptionist at the time of scheduling so an appropriate appointment can be made. If you have twins please inform the receptionist so the appropriate amount of time can be reserved for you and your babies.

Doctors Sherri Thornton and Ellen Haas are dedicated to the care of their patients; however, they may be called out for a delivery or an emergency at any time. We ask for your understanding and patience. We will be happy to offer you an appointment with Taylor Taylor FNP or Courtney Wyatt WHNP. You are always welcome to wait for the return of your physician.

Ultrasounds

It is common to have an ultrasound as part of the routine testing between 18-20 weeks gestation. While most insurance companies will cover both, it is your responsibility to verify this with your insurance carrier.

Laboratory Testing

Routine blood work is performed at scheduled times throughout the pregnancy. See **Schedule of Prenatal Visits and Routine Testing During Pregnancy** for specific labs.

Please notify the nurse at each laboratory visit if your insurance requires a particular lab. A drawing fee is assigned at the time of the collection of the specimen; however, the laboratory will bill you or your insurance directly for the testing.

Initial appointment

Due date will be established and prenatal labs will be drawn. Blood work includes: CBC for blood count, blood type, antibody screen, rubella, RPR (syphilis), Hepatitis B, and HIV. Infants are prone to contracting HIV from an affected mother unless certain precautions are taken. It is for this reason that ACOG recommends all pregnant women be screened for HIV. This will be included in your routine testing unless you state you decline testing.

18-21 weeks

Ultrasound

We recommend an ultrasound around 18-22 week in the pregnancy to evaluate fetal anatomy, and to check the baby's heart, brain, spine, etc. Additional ultrasounds will be performed based on the medical need. At the visit the sex can usually, but not always be seen.

The ultrasound uses high frequency sound waves to produce a picture of your baby. Ultrasounds check for fetal and placental abnormalities; however, they cannot detect all problems. They do not detect genetic abnormalities. You will be given pictures from the visit but videotaping is not allowed. Electronic images are available if you provide us with a flash drive. 3D ultrasounds are available upon request.

Pre-register with the Hospital: Dr. Thornton and Dr. Haas have privileges at Carle BroMenn. Please contact your insurance carrier to determine if this hospital is preferred. Please contact their admitting offices to pre-register. While this is not mandatory it will alleviate stress during your admission.

In order to expedite your admission to the hospital, you should register for each pregnancy. When you go into labor, you will be admitted directly in the labor and delivery floor, without going through the admitting office. See the section for **Important Names and Numbers** for more information.