Verifying Insurances When Scheduling

Any time you schedule an appointment on behalf of a patient, you must verify that the provider accepts the patient's insurance. Not verifying insurance can result in the patient receiving a hefty bill for the total cost of their visit, something nobody wants to have to happen to them.

Schedule as usual if a provider accepts the patient's insurance. If not, you can still schedule, but you must let the patient know they must pay out of pocket.

This job aid provides step-by-step instructions to verify that the provider accepts the patient's insurance.

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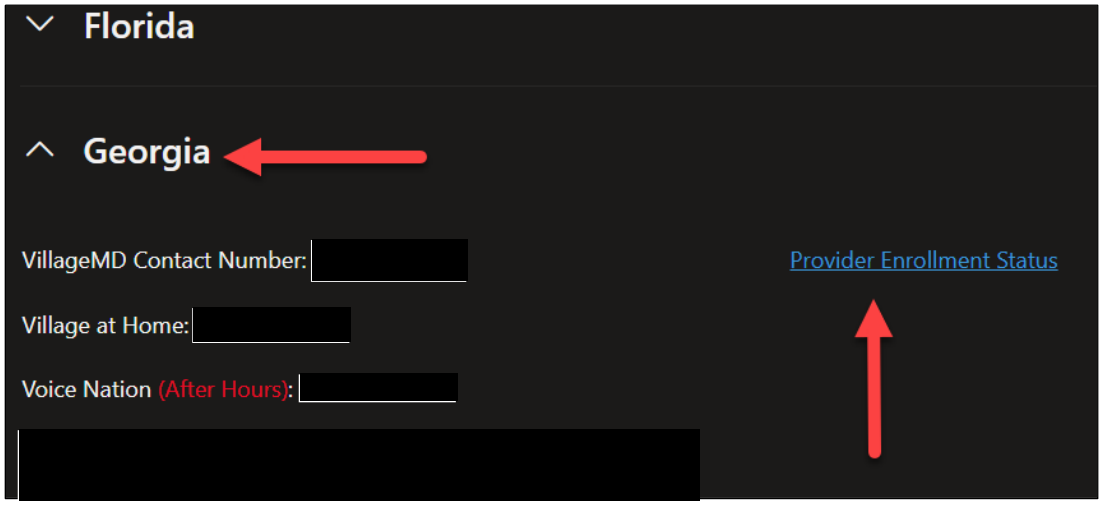
Provider Enrollment Status

The primary insurance resource the Patient Services Center receives comes directly from credentialing. We receive one for every state or market, which you can find on the **Clinics & Providers** page.

During appointment scheduling calls, complete the following steps to verify the patient's insurance:

1. Scroll down the **Clinics & Providers** page to the patient's state.
2. Click on the state name to expand additional information.
3. Click on **Provider Enrollment Status**.



4. Credentialing sets the resource up with a color-coded system. Find the provider on the left side of the table and the insurance on top.
5. A green square equals an accepted plan. A red square equals a not-accepted plan.

NOTE: Some squares are white—this means the plan is in the credentialing process, but count it as **not accepted** until the square turns green.

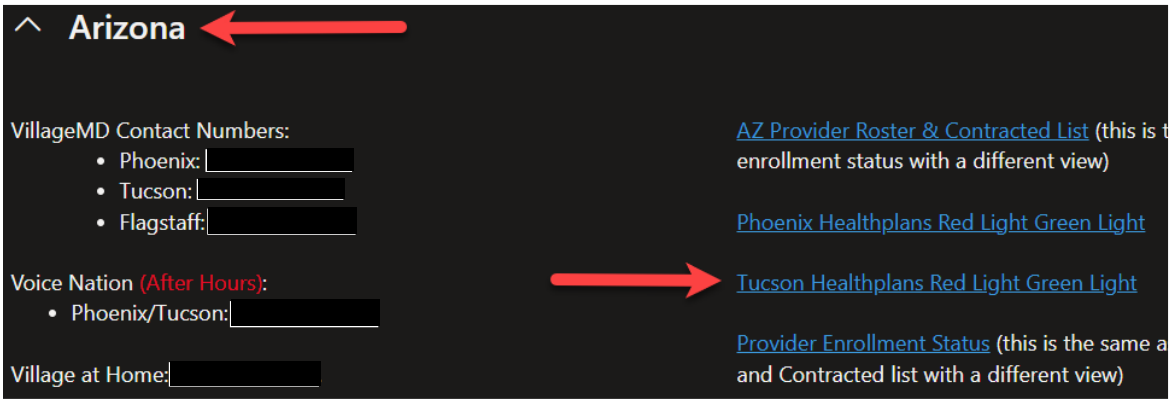
a. For example, if a patient enrolled with [redacted] scheduled an appointment with [redacted] their insurance would cover the plan. However, their insurance would not cover the plan if the patient enrolled with [redacted].

[redacted]

Red Light Green Light Exception

Arizona and Nevada, besides the Provider Enrollment Status job aids, have **Healthplans Red Light Green Light** documents. These documents cover insurance that Village Medical accepts as an organization, so you must verify that we accept the insurance before verifying if the provider does.

1. Click on **Healthplans Red Light Green Light**.



2. Scroll down the PDF or press **Ctrl + Find** and utilize the **Find** function, and search for the patient's insurance.
3. Green text means we accept the insurance, while red text means we don't.
   a. For example, we accept [redacted].

[redacted]

4. If you confirm that Village Medical accepts the patient's insurance, continue to the **Provider Enrollment Status** to verify if their specific provider does.

Texas Exception

Texas is one of few states where credentialing supplies an additional document containing a list of accepted plans. To consider the additional document when scheduling appointments, please complete the following steps:

1. Click on **Texas Contracted Plans**. This document contains the state insurance that Village Medical accepts as an organization.

2. Scroll down the excel spreadsheet or press **Ctrl + Find** to utilize the **Find** function and search for the patient's insurance. Here is an example:

   a. As seen above, Houston does accept [redacted] plans as of July 1, 2019. However, we do not accept [redacted] as of January 5, 2023.
      1) This doesn't mean we accept all [redacted] plans, so remember to gather the patient's insurance information. For example, here are the [redacted] plans that Village Medical accepts:

3. You can also navigate to additional sheets within the spreadsheet; for example, if a patient is enrolled in [redacted], click on the [redacted] sheet.
4. A table near the top of the sheet lists each [redacted] plan, status (participating or not participating), and effective date.

5. If Village Medical is confirmed to accept the patient's insurance, proceed to the **Provider Enrollment Status**, and continue verifying if the specific provider accepts the insurance.

HMO vs PPO

Also keep in mind the difference between a Health Maintenance Organization (HMO) plan and a Preferred Provider Organization (PPO) plan.

	HMO	PPO
What is it?	Health Maintenance Organization (Medicaid and Medicare are typically HMOs)	Preferred Provider Organization
Provider Network	In Network Only	Both In and Out of Network (although Out of Network benefits may be reduced)
Specialty Care (Referrals)	Must see Primary Care Physician assigned with Village by Insurance prior to being seen (PCP) who coordinates all care with other in network providers	Patients can see a specialist without a referral
Cost	Typically, the premiums (cost to patient) is less	Typically, the cost (Premiums and cost at time of treatment) is slightly higher
How does payment at providers work?	Copays	Deductibles and Co-insurance
Claims	Always filed by the provider	INN filed by the provider; OON may have to be filed by the patient

Here are the key takeaways from the graphic above:

- HMO is restrictive, and patients can't go to any provider. Instead, they must see providers only in-network, and the provider must be their PCP.
- If a patient sees an out-of-network provider but the patient is enrolled in an HMO plan, the patient would pay the total price for the visit.
- Under an HMO plan, all treatment is coordinated by the patient's PCP. Referrals are also required for everything.

The graphic is also available on the **Call Center Protocols** page for easier access without opening this job aid to use as a reference.