FAQs about Registration at Johnson Memorial Hospital

Why do I have to verify my address each time?

Though address and telephone numbers remain constant for approximately 70% of us, verifying this information is essential in our billing and collection processes.

Why don't you keep the information available so you can retrieve it without re-entering it?

Demographic information is considered valid for a certain period of time. At Johnson Memorial, 120 days is our revalidation time. Despite verifying the information, we still receive some mail each week with invalid addresses.

Why must I show my insurance card each time?

Insurance coverage changes more frequently than addresses. Your card provides the precertification telephone numbers, claims address and group numbers that are essential to us as your insurance advocate and to the processing of your insurance claim. As an industry standard, insurance information is considered accurate only at the time of service, thus the need for revalidation each time you are seen.

But I have Medicare and it does not change. Why do I have to show my card every time?

Information contained on your Medicare card defines the correct billing expectation Medicare requires. While 99% of the time this does not change, our 120-day revalidation period necessitates that we renew the information in our system.

I am retired and have Medicare. When I come in, you ask about mine and my spouse's employment status. Why?

Medicare is a "last payer insurance." Federal law mandates that all Medicare providers verify at each visit that you or your spouse does not have an Employer Group Health Plan that would be primary over Medicare. When audited, we have to show proof that for each time you received services, you were asked specific questions relating to the possibility of other insurance. Additionally, if you are in an accident and someone else is at fault, the other party is responsible for your medical expenses according to Federal Law.

Sometimes I have to wait for medical tests because you need an "order." What is this?

Similar to a pharmacy filling a prescription, a physician's order must be on file requesting a diagnostic test before we can perform a service. If we do not have a record of the order and it is not presented at the time of service, we must call the physician's office and request the order be faxed. The results are then directed to the ordering physician who will confer with you regarding the results.

Diagnosis

All insurance companies require a valid diagnosis to enable them to determine the benefits due. It is the physician’s responsibility to provide the hospital with a diagnosis. If you have questions concerning the diagnosis, you should contact you physician directly.

Screening-Wellness Testing

If you have benefits under your insurance plan that allows for annual wellness or preventative testing it is important that you tell the Physician and the JMH Registrar. Once a claim is filed with your insurance it becomes an historical fact and cannot be changed by the hospital.

Medicare Patients

The purpose of an ABN is to give the patient notice–before a service is provided–that the hospital believes it is unlikely that Medicare will cover the test, procedure, or therapy that your doctor has ordered. The ABN will list the service, explain why the Medical Center believes Medicare might not pay, and inform you that you will be fully and personally responsible in the event that Medicare does not pay. After being informed that Medicare would not cover a test, if you choose to go ahead and have it, you are accepting responsibility for payment of the service. If an order does not support the medical necessity at the time of the test, it will not support after the test. This can be construed as Fraud & Abuse.

Commercial Payers

Commercial carriers will ask for the medical records anytime a change in the diagnosis is made to make sure JMH is not committing insurance fraud by trying to get the member better payment. IF the insurance plans only look at the first diagnosis and the diagnosis is coded and on original Order, we inform them that this was not correct that all diagnosis needed to be considered. When the diagnosis is not present on the original order it becomes the patient/insured responsibility to work with their insurance carrier to collect the benefits of their insurance plan.

Medications for Medicare outpatients

Drugs that are considered self-administered and drugs that can be used at home are not covered by Medicare in the outpatient setting. The outpatient setting is: Observation, Emergency Room and Same Day Surgery. These charges will be billed to you on a Medicare Part D statement that will have the required information necessary for submission to your Medicare Part D Drug Plan.

Questions

General information: 317.738.7880
Copy of your itemized bill: 317.738.7878