

## ISOMS INSURANCE COMMITTEE REPORTING SHEET

The following form is intended to ease reporting of the specific problem you have encountered.

You should supply the requested information in detail, but not include any patient identifying information (such as name, address, birth date, social security number, policy I.D. number etc.). You should however retain any documentation regarding the problem, especially any written communications and EOBs from the insurance company.

Your name \_\_\_\_\_ Office Address \_\_\_\_\_

Phone number \_\_\_\_\_ Email Address \_\_\_\_\_

Does the problem fit any of the following categories?

1. \_\_\_\_ **Silent PPO:** the insurance provider reduced and limited the fee you may charge the patient because you are listed as a contracted provider, even though you do not think you have a contract.
2. \_\_\_\_ **Not medically necessary:** the insurance provider will not provide benefits because they have determined the procedure is not medically necessary, or they require a physician to certify the treatment is medically necessary.
3. \_\_\_\_ **Not a covered benefit:**
  - a. \_\_\_\_ Removal of asymptomatic/ non pathologic third molars
  - b. \_\_\_\_ Anesthesia/ sedation in conjunction with a service.
  - c. \_\_\_\_ A specific procedure, but the insurance carrier is attempting to limit your fee for the non-covered procedure.
  - d. \_\_\_\_ Anesthesia services are covered only if provided by a practitioner separate from the surgeon.
4. \_\_\_\_ **Degree of Provider Discrimination:** the insurance company would provide benefits for the procedure if it were performed by an M.D.
5. \_\_\_\_ Coverage **only if performed in accredited surgicenter:** the insurance company will reimburse for an outpatient procedure only if it is performed in an accredited surgicenter.
6. \_\_\_\_ **Diminishing coverage for multiple procedures;** i.e. the insurance company is paying 100% for first impaction, 50% for second impaction.
7. \_\_\_\_ Other: \_\_\_\_\_

Dental Insurance

Plan: \_\_\_\_\_

Type: \_\_\_ Traditional Indemnity \_\_\_ PPO \_\_\_ HMO \_\_\_ POS \_\_\_ ERISA (self funded)

Medical Insurance

Plan: \_\_\_\_\_

Type: \_\_\_ Traditional Indemnity \_\_\_ PPO \_\_\_ HMO \_\_\_ POS \_\_\_ ERISA (self funded)

Procedure Codes In Question: CDT \_\_\_\_\_

CPT \_\_\_\_\_

ICD \_\_\_\_\_

Month and Year of Procedure: \_\_\_\_\_

Please **do not include any patient identifiable information**. Release of patient information could result in violations of HIPAA and/or state privacy laws.

Concise Narrative of Problem: (Use an extra page is necessary.)

Your Full Name \_\_\_\_\_ Phone \_\_\_\_\_

4.2.02

Feel free to attach extra sheets and use this form as a guide for reporting your insurance problems.

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