AH PRESCRIBING

# How To: Getting Insurance Coverage for Private-Pay Services

**It is increasingly common that small specialty medical and therapy practices are “private pay only.” Sometimes, even when a practice is “self-pay only,” services are still eligible for insurance coverage. The process works a little differently than “in-network” services and requires a bit more paperwork from the patient , but it can be well worth it to ensure you’re able to access treatment with a provider who is a good fit for you.**

The following FAQs address  how “out-of-network” insurance coverage works, and how to go about getting payment from your insurance company for specialty services. This information is not meant to take the place of contacting your insurance provider(s) to understand their exact processes.

### What do “private pay only” and “out-of-network” mean?

“Private pay only” clinics and practices do not contract with any insurance companies. This means they determine their own rates, rather than an insurance company dictating the rate. . Many insurance companies mandate very low reimbursement rates for specialty providers, which is why it is common for these practices to be private pay only.

“Private pay only” generally means the same thing as “out-of-network” services. As long as the provider is a certified, licensed medical or behavioral health professional, their services generally qualify for insurance coverage. A private pay only provider might tell you that they don’t “take” your insurance. This means the provider is unable to submit claims on your behalf. However, you may be able to submit claims and be reimbursed. This arrangement is referred to as “out-of-network” care.

### How are claims submitted?

If you normally see providers who “take” your insurance (in other words, they are in-network with your plan), your visits probably look like this:

1. You give your insurance card to the provider’s office.
2. The provider submits the claim to insurance on your behalf.
3. You pay a copay at the visit (sometimes).
4. You receive a bill from the provider’s office several weeks after the visit. The provider sends this bill to you only after they receive the claim back from your insurance plan.

Your insurance plan tells the provider how much to charge you, which is what is in the bill that you receive.

**Out-of-network (private pay only) providers typically work like this:**

1. You pay the full cost of the visit before or at the time of service.
2. The provider gives you a special receipt, showing the amount you paid and all the medical information about the visit. This is called a "superbill".
3. You submit this superbill to your insurance company yourself.
4. If the service is approved by your insurance plan, your insurance company will mail you a check for the covered amount.

**Is out-of-network coverage the same as in-network coverage? In the vast majority of cases, the answer is no.**

Some plans (including nearly all HMOs) do not permit any out-of-network coverage. If you choose a provider such as AH Prescribing who is out-of-network/private pay, your insurance plan won't cover anything.

Many PPO plans cover both in- and out-of-network services. Usually, in-network services are reimbursed/paid at a higher rate than out-of-network services. For example, your insurance plan may pay 80% of the insurance-allowed cost amount* for in-network services, but only 60% for out-of-network services.

Some plans may require additional paperwork to get out-of-network services covered, such as a preauthorization or precertification. This basically means that you need to submit paperwork to insurance before services begin, alerting the insurance plan that you intend to see an out-of-network provider. Even if the diagnosis and service is generally approved by your insurance, failure to complete this paperwork can result in denial of any out-of-network claims. If you plan to submit claims yourself using a superbill provided by AH Prescribing for out-of-network reimbursement, it's important to check if your plan has any preauthorization or other paperwork requirements.

**What does "allowed amount" mean?**

All insurance companies have "allowed amounts" for different health care services. This is the reimbursement rate that the insurance plan has decided they will pay for a given service. In-network providers are contractually obligated to honor this rate, and charge only what the insurer dictates. Private pay/out-of-network providers determine their own rates. (JM original phrasing seems like price gouging)

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If your plan covers out-of-network services at, say 60%, that is usually written as 60% of the allowed amount. This is usually different than what the provider actually charges.

**Here's an example:**

1. Your insurance plan has an "allowed amount" of $100 for one visit of speech therapy.
2. Your out-of-network provider charges $150 for one visit of speech therapy.

3. Your insurance plan covers out-of-network services at 60% of the allowed amount.
4. This means that your insurance plan will pay 60% of $100 (the plan's rate), NOT 60% of $150 (what you paid the provider).

**When you visit your provider:**

1. You pay $150 to the practice at the time of service.
2. You submit your claim to your insurance company.
3. If approved, they will send you a check for $60 - which is 60% of your plan's allowed amount, NOT 60% of what the provider charges.

**Summary: How to get out-of-network / private pay services reimbursed by insurance**

1. Check your plan information to see if you have out-of-network benefits.
2. If yes, check to see if preauthorization or other advanced paperwork is required.
3. Contact your plan to get information on how to submit claims to them yourself (snail mail, online through your member portal account, etc.).
4. Ask your provider if they can provide you with a superbill so that you can submit a claim to your insurance company (the vast majority will say yes).
5. Pay your provider the full amount at the time of service.
6. Receive a superbill from your provider.
7. Send the superbill to your insurance plan, following the plan's requirements.
8. Receive a check in the mail from your insurance plan