



Name _____

Date of birth _____

MRN _____

BILLING INFORMATION FOR PATIENTS WHO HAVE APPOINTMENTS IN A MOUNT SINAI PROVIDER-BASED PRACTICE

When you receive services in a Mount Sinai outpatient practice or clinic, depending on the services rendered, you may receive two bills. Services provided in a Mount Sinai outpatient practice or clinic will have two separate components as noted below.

- **Hospital Services:** covers the use of the room and any medical or technical services, supplies or equipment. Often referred to as a facility and/or treatment room charge.
- **Physician and Clinical Professionals:** covers your doctor's professional services, treatment or procedures

The facility and/or treatment room charge is the result of Mount Sinai's outpatient practice and clinic locations being classified as hospital outpatient departments, also called provider-based* facilities.

Provider-based billing applies to all patients, regardless of the type of insurance you have. The way your insurance covers facility and/or treatment room charges will be different, based on whether you have insurance through your employer, some other insurance company, or if you are covered by Medicare.

How this affects you if you are covered by your employer health plan or other insurance (not Medicare): The way your insurance company handles these charges will vary based on your health plan. Some insurance companies may apply these charges to your annual deductible. To find out what will be covered, contact your insurance company. If you have additional questions about these

charges or anticipated cost, **kindly contact one of our practice managers or one of our practice financial counselors.**

How this affects you if you have Medicare:

- **The Hospital Services** charge(s) will be billed to Medicare Part A.
- **The Physician and other Clinical Professional** charges will be billed to Medicare Part B.

You will receive two Medicare Summary Notices (MSNs): one for Part A and one for Part B:

- If you have secondary insurance, we will submit any balance to that insurance company.
- If your secondary insurance does not cover the remaining balance or if you do not have secondary insurance, the balance will be billed to you.

Medicare requires that we give you an **estimate** of your Part A and Part B charges if you do not have secondary insurance. These amounts may be different, depending on the services you receive. Here is an estimate of what a Medicare patient may be responsible **for if there is no secondary insurance. If you have secondary insurance your responsibility will change based on your secondary coverage.**

See the practice financial counselor for additional estimates or contact the practice at:

Example Services	Part A Co-Ins	Part B Co-Ins	Example Services	Part A Co-Ins	Part B Co-Ins
Office visit Est level 2	\$27.13	\$5.81	Office visit Est level 3 w/EKG	\$27.13	\$13.49
Office visit Est level 3	\$27.13	\$11.57	Office visit Est level 3 w/flu vaccine	\$27.13	\$11.57
Office visit Est level 4	\$27.13	\$17.81	Chest X-Ray	\$14.59	\$2.08

*Provider-based is a Medicare classification. It means that hospitals have met specific Medicare regulations to have their outpatient doctors' offices and clinics classified as provider-based. Most large hospital systems are classified as provider-based by Medicare, which results in uniform billing. Provider-based billing applies to all patients, not just Medicare patients.

Please sign below, acknowledging that you have been made aware.

Signature of patient or authorized representative _____ Relationship to patient _____ Date _____

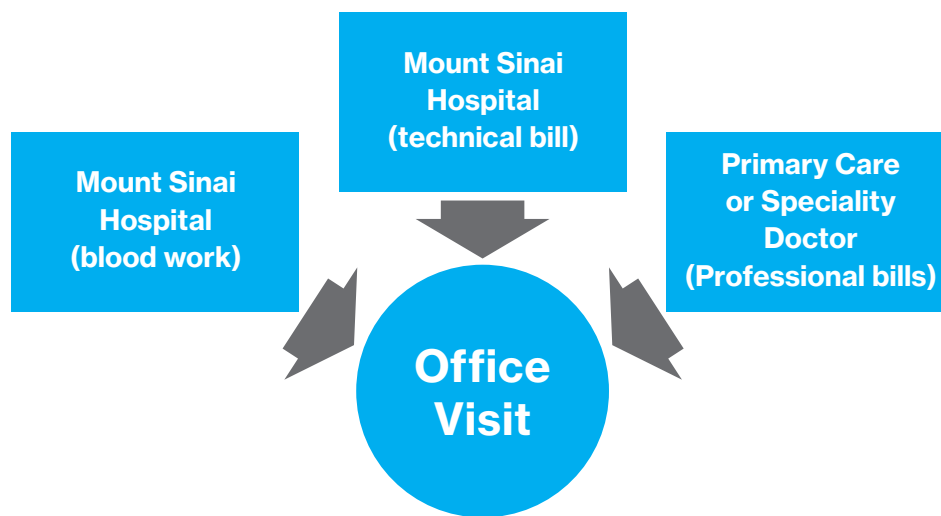
EXPLANATION OF CHARGES

Hospital Services

Patients seen in an outpatient setting may receive separate invoices for some services, including laboratory (e.g. blood work) services, pathology (e.g. biopsy) services, and radiology (e.g. X-ray, MRI, CT, etc) services. This outpatient bill will include charges for the use of the facility, equipment, supplies, and technical personnel. For scheduling reasons, some tests or procedures may be performed at a later date and will be billed separately from your outpatient invoice.

Physician and Clinical Professionals

Physician fees will be billed for the professional consultative and interpretation services. Some physicians and/or physician groups may send you separate invoices that include the cost of medical or surgical care as well as costs involving review and interpretation of your diagnostic tests. For example, you might receive a bill from the specialist or primary care physician who is managing your care, the pathologist who examines your biopsy, or the radiologist who reads your X-ray.



Below are frequently asked questions (FAQs) related to Provider-Based Hospital Outpatient departments.

Q: What does “Provider-Based” or “Hospital-Based Outpatient” mean?

A: “Provider-Based” or “Hospital-Based Outpatient” refers to the billing process for services provided in a hospital outpatient clinic or location. This is a Medicare status for hospitals and clinics that meet specific Medicare regulations and requires that we bill Medicare in two parts (Part A and Part B).

Q. How does this affect patients?

A: Patients may receive a charge from the hospital and the doctor in a hospital outpatient clinic. If a patient has insurance, each patient’s insurance plan is unique to that patient and contracted provider. Some insurance companies may cover both hospital charges and doctor charges and some may not.

Q: What should I ask my insurance carrier?

A: Ask whether the insurance company covers facility charges in an outpatient hospital clinic. If it does, ask what percentage of the charge is covered. Additionally, verify what your hospital outpatient insurance benefits are, as they typically are applied toward a hospital deductible and coinsurance payment.

Q: How does this affect a patient who has Medicare or Medicaid?

A: In a hospital-based outpatient clinic, Medicare and Medicaid patients may receive two (2) separate bills for services provided in the clinic – one from the doctor and one from the hospital. Adult Medicaid patients will pay two copayments for the office visit - \$3 for the physician service and \$3 to the hospital.

Depending on the clinical service being provided, additional out-of-pocket expenses for Medicare and Medicaid patients may be incurred in the “Provider-Based” clinic.

Q: What if a Medicare or Medicaid patient has secondary insurance coverage?

A: Co-insurance and deductibles may be covered by a secondary insurance policy. Check with your benefits or insurance company for details related to your secondary coverage. For instance, you may ask whether the secondary insurance company covers facility charges or provider-based billing. If it does, ask what percentage of the charge is covered. Verify what your hospital outpatient insurance benefits are, as they typically are applied toward your deductible and coinsurance.

Q: Where can patients call with their financial questions or concerns?

A: The Hospital and the Faculty Practice have staff available to assist with questions. If you already have received services and have questions pertaining to your statement, please call the telephone number referenced on your bill.

Q: Why does the Medicare Secondary Payer (MSP) questionnaire need to be completed?

A: As a participating Medicare provider, we are required to screen Medicare patients according to the MSP rules. If it pertains, at each visit, you will be asked the MSP questions. These questions help us to confirm if Medicare or another payer should process the insurance claim as primary.