Teton Valley Hospital Frequently Asked Billing Questions:

Why do I receive so many bills when I visit the hospital?
Every hospital visit involves both physician and hospital resources. Although physicians are licensed to practice at the hospital and may even be employees of the hospital, physicians and hospitals have different coding and billing systems and requirements. You will therefore receive separate bills for hospital and physicians services.

I see the same item listed on the doctor's bill and the hospital bill and I think I've been double charged. How did this happen?
Every hospital visit involves both physician and hospital resources. Although the hospital and the provider may use the same language to describe each charge, their bills are for separate services. The provider's bill will be for professional assessment, direction and oversight. The hospital's bill will be for the technical resources, including supplies, needles and scalpels, medications, procedures and other equipment required for your treatment.

Why did I receive a bill if I have insurance coverage?
You will receive a statement from the hospital at the same time your insurance is billed to ensure you are aware of the amount billed to your insurance. After your insurance pays their portion, you will receive another statement showing any remaining amount that you owe based on what your insurance communicates to us on an Explanation of Benefits (EOB). Your insurance also mails you an EOB and this document details how your insurance calculated your responsibility. Contact your insurance directly (the number is likely to be on your insurance card or EOB) if you feel your responsibility is inaccurate.

I can't pay my bill in full. What should I do?
Teton Valley Hospital offers payment options, including monthly payment installments. Don't ignore your bill or send in less than full payment without contacting us. This may cause your bill to progress through our collections process, including transfer to a collection agency where it may appear on your credit report. To discuss your bill and payment options, please call our Financial Counselor at (208) 354-6331.

Frequently Used Billing Terms Defined:

Account number (visit number). The unique reference number assigned to each hospital encounter.

Adjustment. A transaction that increases or decreases your accounts receivable balance. A debit increases your balance and a credit decrease your balance.

Assignment of benefits. An agreement in which you instruct your insurance organizations to pay the hospital, physician or medical supplier directly for your medical services. Your insurance organization decides the payment rate and your responsible portion.

Bad debt. Debt that is uncollected after several attempts. Teton Valley Hospital refers such debts to a collection agency

Balance. Amount outstanding on your account. Your statement will indicate who currently owes the balance.

Charge itemization. A list of all items, medications, room charges and procedures. This does not necessarily indicate amount owed by you or your insurance.

Claim. A form submitted to the insurance organization for payment of benefits.

Co-insurance. The part (usually a percentage) of the covered health care cost for which you are financially responsible. Often, co-insurance applies after you meet your deductible.

Coordination of benefits. How insurance organizations determine the primary payment source when you are covered under more than one insurance organization or group medical plan. Many insurance contracts state that if you are covered under more than one insurance plan, benefits will be coordinated so that total benefits paid will not be more than 100% of the bill.

Co-payment. The contractual provision that requires you to pay a specific charge for specific service, usually when you receive the service. A co-payment usually applies to office visits, prescriptions, emergency or hospital services.

Covered services. Specific services or supplies for which your insurance reimburses you or pays your health care provider. These consist of a combination of mandatory and optional services and vary by state.

Deductible. The agreed amount you must pay before your insurance organization will pay a claim. Usually, you have 12 months to meet your deductible. Eligible expenses after you meet your deductible are then paid for the rest of that 12-month period.

Disallowed amount. The difference between the charge and the amount your insurance organization approves. If your health care provider is under contract with your insurance organization to accept the approved amount, you aren't billed for the difference. If your provider is not under contract, you may be billed for this difference.

Group number. The number of your insurance organization group. See your insurance card.

Guarantor. The individual responsible for paying this bill. Patient statements are addressed to this person.

Ineligible expense. A charge your insurance organization will not pay because it is not covered by your insurance plan. If your health care provider is under contract with your insurance organization, this charge may be billed to you.

Limit of allowance (contractual allowance). The difference between what your insurance organization approves and your health care provider charges for a procedure. You are not billed for this difference when your health care provider is under contract to accept your insurance organizations' approved amount. This difference shows up on your account as an account adjustment, decreasing the balance.

Non-participating health care provider. A health care provider who is not under contract with an insurance organization to accept patients and receive the insurance organization's approved amount on all claims. You pay the difference between its approved amount for a service and this health care provider's charge.

Participating health care provider. A health care provider who contracts with an insurance organization to accept patients and receive the insurance organization's approved amount on all claims.

Place of service. The facility where service is performed.

Policy number. The number on your insurance policy. See your insurance care.

Policyholder. The name of the person who took out or purchased the insurance policy. This person owns the policy. Also called a subscriber or guarantor.

Pre-authorization (pre-certification). The process of getting permission from your insurance organization for certain services before they are provided so that the services can be considered eligible expenses. Usually required for hospital and outpatient services. It is usually the patient’s responsibility to ensure that the services are preauthorized.

Primary insurance. The insurance organization with first responsibility for paying eligible insurance expenses for your medical service (after you have paid your deductible and co-payments). If you have additional insurance, those organizations would work with your primary insurance organization to cover eligible expenses according to your insurance policies.

Referral. Written authorization from your health care provider to see another health are provider. For example, your primary care provider may provide written authorization for you to see a specialist.

Secondary insurance. The insurance organization with second responsibility for paying eligible insurance expenses for your medical service (after you've paid your deductible and co-payments). This insurance would work with your primary insurance organization to cover eligible expenses according to your insurance policies. This insurance organization is billed second - after your primary insurance organization has been billed.

Subscriber. The person who purchased the insurance. Also known as a policyholder or guarantor.

Tertiary insurance. The insurance organization with third responsibility for paying eligible insurance expenses for your medical service (after you've paid your deductible and co-payments). This insurance would work with your primary and secondary insurance organizations to cover eligible expenses according to your insurance policies. This insurance organization is billed third - after your primary and secondary insurance organizations have been billed.

Units. The number of a particular item that were ordered and received.