Standard Operating Procedure (SOP): Insurance Eligibility and Coverage Verification Process

This SOP details the **insurance eligibility and coverage verification process**, including steps to verify patient insurance details, confirm coverage benefits, identify co-pays and deductibles, handle prior authorizations, update patient records, and communicate with insurance providers. The goal is to ensure accurate and efficient verification of insurance information to facilitate billing, reduce claim denials, and enhance patient service.

1. Purpose

To standardize the process for verifying insurance eligibility and coverage for all patients, ensuring accurate billing and minimizing claim denials.

2. Scope

This SOP applies to front office staff, billing personnel, and any staff involved in patient registration and insurance verification at [Organization Name].

3. Procedure Steps

1. **Collect Patient Insurance Information**
   - Request a copy (or scan) of the patient's insurance card (front and back).
   - Update patient demographics and insurance details in the practice management system (PMS).
2. **Verify Insurance Eligibility**
   - Access payer portal or use telephone verification to confirm active coverage.
   - Document insurance eligibility, including dates of coverage and type of plan.
3. **Confirm Coverage Benefits**
   - Verify coverage for scheduled services (e.g., office visits, procedures).
   - Check plan limitations, exclusions, and network status.
4. **Identify Co-pays, Deductibles, and Co-insurance**
   - Confirm patient financial responsibility for scheduled services.
   - Document co-pay, deductible, and co-insurance information in the patient record.
5. **Handle Prior Authorizations (if applicable)**
   - Determine if services require pre-authorization.
   - Submit required documentation and obtain authorization number before service is rendered.
6. **Update Patient Records**
   - Record all details of insurance verification in the patient's electronic health record (EHR) or PMS.
   - Attach supporting documentation (e.g., screenshots, confirmation numbers).
7. **Communicate with Insurance Providers (as needed)**
   - Contact insurance companies for clarification or additional benefit details.
   - Document all communications, names of representatives, and reference numbers.
8. **Patient Communication**
   - Notify patient of any coverage issues, out-of-pocket expenses, or prior authorization requirements.

4. Documentation

- Insurance verification form/worksheet (manual or within EHR/PMS)
- Copies of insurance cards
- Benefit breakdown (uploaded or attached to records)
- Prior authorization approvals (if applicable)

5. Roles and Responsibilities

Role	Responsibilities
Front Desk/Registration Staff	Collect insurance information and update patient records.

Billing Staff	Verify insurance, document benefits, identify co-pays/deductibles, and process authorizations.
Management/Supervisor	Ensure compliance, provide training, and monitor performance.

6. Quality Assurance

- Regularly audit insurance verifications and documentation.
- Monitor for claim denials due to verification errors.
- Provide retraining and process improvements as needed.

7. References

- [Insert payer portal links and contact information]
- [Organization policy for patient financial responsibility]
- [Relevant compliance guidelines: HIPAA, etc.]