SOP: Insurance Verification and Eligibility Checks

This SOP details the process for **insurance verification and eligibility checks**, including the collection of patient insurance information, verification of coverage status, confirmation of policy benefits, checking for prior authorizations, coordination with insurance providers, and documentation of all verification activities. The goal is to ensure accurate and timely verification to facilitate smooth billing processes and prevent claim denials.

1. Purpose

To outline standardized procedures for verifying patient insurance coverage and eligibility prior to the delivery of services.

2. Scope

This SOP applies to all front office, billing, and administrative staff responsible for patient registration, insurance verification, and billing processing.

3. Responsibilities

Role	Responsibilities
Front Office Staff	Collect insurance information, enter data into system, initiate verification.
Billing Department	Assist with complex verifications, prior authorizations, and resolve coverage issues.
Manager	Oversight, training, and continuous improvement of verification processes.

4. Definitions

- **Verification:** The process of confirming the validity and details of a patient's insurance policy and coverage.
- **Eligibility:** The determination of whether a patient's insurance is active and covers the intended services.
- **Prior Authorization:** Approval from the insurance provider for specific services before they are rendered.

5. Procedure

1. **Collect Patient Insurance Information**
    - During appointment scheduling or registration, request all insurance cards and photo identification.
    - Collect complete insurance information: policyholder name, policy number, group number, provider contact, and effective date.
    - Enter or update details in the Practice Management/EHR system.
2. **Verify Insurance Coverage Status**
    - Contact insurer via online portal or phone or use electronic verification tools (EDI/real-time eligibility tools).
    - Confirm active coverage and effective dates.
    - Identify primary and secondary insurance, if applicable.
3. **Confirm Policy Benefits**
    - Determine covered services and specific plan details relevant to the patient's upcoming appointment or treatment.
    - Obtain information on co-payments, deductibles, co-insurance, exclusions, and coverage limits.
4. **Check for Prior Authorization Requirements**
    - Identify if prior authorization is needed for proposed procedures or services.
    - If required, initiate prior authorization process following insurer protocols.
    - Obtain and document authorization number and expiration date.
5. **Coordinate with Insurance Providers**

    - Clarify benefit information or resolve discrepancies by direct contact with insurance representatives, if necessary.
6. **Document Verification Activities**
    - Record verification date, method (online/phone), outcome, benefits summary, and any authorization information in the patient's record.
    - Escalate unresolved issues to the billing or manager for follow-up.
7. **Communicate with Patient (as needed)**
    - Inform patient of their coverage status, co-pay, deductibles, or any out-of-pocket obligations prior to service delivery.
    - Answer basic coverage questions within scope of knowledge.

6. Documentation

- All insurance verification and eligibility checks must be dated and documented in the patient's electronic record.
- Maintain copies/scans of insurance cards and authorization confirmations.

7. Quality Assurance & Compliance

- Managers shall periodically audit verifications for completeness and accuracy.
- Ongoing staff training on insurance processes, payer requirements, and compliance mandates (e.g., HIPAA).

8. Reference Links

- Centers for Medicare & Medicaid Services (CMS)
- American Medical Association (AMA)
- HIPAA Information

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