Understanding Your Medical Insurance

Navigating Your Insurance Coverage

When your child has a special health care need, developmental delay or disability, it is important to understand your insurance coverage. You are encouraged to learn more about your health insurance benefits and how insurance may be used to contribute to funding your child's early intervention program. You can use the attached Insurance Verification Worksheet with more detailed tips to gather this information to share with your Family Resources Coordinator (FRC) and Early Intervention Team.

Learn About Your Plan

Learning about your coverage will help you make the best decisions to meet your child's needs. Your insurance plan has a Summary Plan Description, a document that summarizes your coverage and provides some guidance on how to find providers who accept your insurance and/or are in your network. Depending on your employer and the insurance provider, this may be a paper document or information you can read online. To find the information about your plan, contact your employer's human relations department or the member service information on your insurance card.

General Questions to Ask About Your Plan

Beyond the basics of learning what your plan covers, it is important to learn about the rules required for coverage:

- Does your plan require a referral from your doctor or other service provider to see a specialist?
- Does your plan require a referral to see a specific therapist/program providing early intervention services (i.e., Physical Therapist, Occupational Therapist, Speech Therapist, Nutritionist)
- How do you obtain a referral? Office visit? Notice in advance? Other?
- How many therapy visits does my plan cover in a year? Does the referral require renewal? Can you get approval for more visits over the phone or do you need to schedule another visit with the primary care doctor?
- What appointments, test and procedures require pre-authorization? Can the doctor obtain the pre-authorization or do you need to contact your health plan directly?
- Are you required to use only providers who have agreed to be covered by the plan (in-network providers)?
- If you can also see doctors or other medical service providers who are not part of your plan (out-of-network coverage), what rules does the plan have for seeing these doctors or other service providers? What will it cost you to use an out-of-network provider?
- Can you see a doctor or other service provider who is not in your plan's network in an emergency or when traveling? If so, what will the cost be to you?

Contact:

Department of Children, Youth & Families Early Support for Infants and Toddlers Program
PO Box 40970 Olympia, Washington 98504-0970 | **esit@dcyf.wa.gov**
www.dcyf.wa.gov/services/child-development-supports/esit

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Medically Necessary

Even if you know what benefits your health plan will cover and how the billing works, you may still have problems with getting your child's early intervention services covered. "Medically necessary" is the term that insurance companies use to determine the medical need for a particular treatment or procedure. This definition is used as a determining factor of payment for treatment and procedures your child may need.

You should always look for your plan's definition of medical necessity; any definition of medical necessity has room for interpretation. If you need to prove medical necessity, a letter can be written by your Primary Care Provider, or other medical provider requesting the service.

Appealing a Denial

If your health plan has not paid for a service or will not agree in advance to a service, then you have the option of appealing the health plan's decision. While your FRC or service provider may be able to work with you and your health plan to get information on why the insurance is not paying for the service, you are responsible to initiate an appeal. The information on the appeals process for your health plan is in the Evidence of Coverage. The process for a Health plan appeal will vary from health plan to health plan so you should familiarize yourself with the process at the same time you are reviewing your coverage. Your plan's Explanation of Benefits (EOB) form will tell you if a service is covered or not. Your health plan does not have to cover all services for your child and you should first check the Evidence of Coverage booklet to make sure your plan covers the denied service. In general, the following steps can be taken:

- If you believe the service has been denied in error, you can contact your plan by phone to discuss your EOB. This is an informal review process. Make sure you get in writing any outcome from an informal review as you cannot appeal a phone call.
  - Keep a record of every phone call to your plan with the name of the person you talked to and notes of the conversation. If the health plan representative will get back to you with information, make sure you find out when you can reasonably expect a reply and follow up with the health plan if you have not heard back.
- If your customer service representative says your plan will not cover a service, you can still submit a claim for coverage. You will need the written denial if you want to proceed to a formal appeal.

  - If you decide to file a formal appeal, it must be in writing.
    - Your health plan may have an appeal form.
    - If not, the Evidence of Coverage will describe the appeal process.
    - Always keep a copy of your written appeal.
- Expect to provide the following information in an appeal
  - Your name, address, and telephone number
  - Your member identification number or Social Security number
  - Copies of the Explanation of Benefits (EOB) forms and your provider's name and billing form
  - Description of the service or procedure you want covered
  - Information supporting why the service should be covered

You may have to file your appeal within a specified period of time. Appeals filed outside the allowed time period will not be considered by the health plan. In some cases, the plan may have a special procedure for urgent cases.

For more information on Insurance regulations in Washington State, call the Insurance Consumer Hotline at 1-800-562-6900.

For more information on health care financing for children who have a special health care need, developmental delay, or disability, call Family Voices of Washington State at 1-800-5-PARENT.

Insurance Verification Worksheet

Child's Name: _____ Parent's Name: _____

Child's DOB: _____ Child's Diagnosis: _____

Referring Physician: _____

Insurance Information: *Please phone your Insurance Company and fill out this form the best you can. This is very helpful information if you are unfamiliar with your coverage.*

Name of Insurance: _____ Phone: _____

Claims Address: _____

Insured's Name: _____ ID #: _____

Plan/Group #: _____ Effective Date of Policy: _____

When you call, be sure to write down the name of the person that you talk to for later reference.

Contact Person: _____Date, Time of call: _____

Say, "I'm calling to clarify my benefits and coverage for neurodevelopment benefits." (They will ask for your member ID #) Ask enough questions to complete all of the information. Incomplete information will require another phone call.

Is my therapist/EI Program, _____ , on the Participating Provider List?

If your therapist/EI Program of choice is NOT in their network, then ask these questions:

"Does my policy allow me to choose my own therapist?" _____

_____

_____

"Can I go outside of my network or the provider list?" (If so, "Is my coverage different, and what difference? Will I be billed for the difference?")

_____

Then ask: "What is my":

Co-pay: _____ % or $ _____ /session. Is the co-pay or coinsurance per day ☐ or per therapy? ☐

For example, if your child sees OT and Speech and you have a $15 co-pay, do you owe $15 per therapy that totals $30 or only $15 per day regardless of how many therapies you see.

Deductible? ☐ No ☐ Yes Amount of Deductible $ _____ / family or individual?

Deductible per Calendar Year? ☐ Yes ☐ No Monthly deductible begins: _____

Has any Deductible been met for this year? ☐ Yes ☐ No If yes, how much? _____

What are the dates for my benefit year: _____ to _____

What is my maximum out-of-pocket expenses?_____

What is my lifetime maximum? $_____ How much has been met to date? $_____

Is the lifetime maximum per family or per person?_____

How many visits are allowed per year, per therapy (ask about all therapies –Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST) – even if your child only needs one, so you do not have to call again in the future)? _____ visits for OT,_____ for PT,_____for Speech.

Any benefits used to date? ☐ Yes ☐ No If yes, explain:_____

Is pre-authorization from my Primary Care Provider needed? ☐ Yes ☐ No

Is pre-authorization from my Primary Care Provider required for specific services such as OT, PT and Speech? ☐ Yes ☐ No

Is a prescription from my Primary Care Provider needed? ☐ Yes ☐ No

Is a prescription from my Primary Care Provider required for special services such as OT, PT, and Speech? ☐ Yes ☐ No

If yes, ask what they need (i.e., medical records, prescription, evaluation, letter of medical necessity, etc) in order to pre-authorize visits or give you a prescription: _____

_____

_____

How many sessions the authorization/prescription covers: _____

What periods of time will the authorization/prescription cover: _____to_____

Can we get more visits approved once we have exhausted the visits? ☐ Yes ☐ No

Are the following codes covered?

Therapy	Code	Yes	No

Does my policy have any exclusion clauses such as "therapy will only be covered if the deficit is due to accident, illness or injury"? ☐ Yes ☐ No

If yes, what is the clause: _____

What address do you mail your claims to? _____

_____

***If you have a secondary insurance policy, fill another one of these forms out for that insurance as well.

If you have a Health Savings Account or other type of account that pays for medically necessary services, talk with your service provider about how these benefits may be used for early intervention services.

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