Patient Billing Frequently Asked Questions

What is the BWH Patient Billing contact information?

Phone: 617-726-3884 **e-mail: patientbilling@partners.org**

Why would I get more than one bill for the same service?

Your Dermatology visit will either be at a hospital based practice or a physician practice. If seen at a hospital based practice (locations on reverse), you will receive separate bills from the hospital and the doctor. The hospital portion is for items such as medical equipment, technology, medical supplies, lab tests, radiology, and treatment rooms. The professional portion is for the time the caregiver spends during the visit treating you, reading test results, and coordinating care.

It is your responsibility to know what is covered by your individual insurance plan. We are unable to keep track of all the different plans of each insurer. Calling your insurance company before a visit may help you understand what is covered and what is not. We are required by law to bill according to the services that are rendered by your physician and we cannot alter our billing to get you coverage for things your insurance will not cover.

- Many Dermatology procedures done in an outpatient setting may be considered outpatient surgery by your insurance. These could include cryotherapy ("freezing"), biopsies, injections and other dermatologic procedures.
- Some Dermatological procedures that do not pose a threat to health may be not covered by your insurance carrier. These may include, but are not limited to, skin tag removals, wart treatments or corn and callous treatments.
- Elective cosmetic procedures require payment at the time of your service.
- **We realize Dermatology billing can be complex. Unfortunately, some insurers place significant restrictions on what they will pay for and we are bound by that. Ultimately, if you are unhappy with your coverage or costs, changing your insurance may be your only option.**

Why would I receive a bill?

- You don't have health insurance.
- We were unable to determine your active coverage.
- The service you received is not covered by your insurance.
- You have a copayment, co-insurance, or deductible that you did not pay at your visit.
- You did not get a required referral from your doctor.
- You received care outside your provider network.
- You used up your insurance benefits. (Some health insurance companies limit coverage.)

What is a coinsurance?

Coinsurance is a percentage of the health care bill that you pay. For example, you pay 20% and your insurance company pays 80%. Your out-of-pocket cost is based on the total amount that your insurance has allowed for the visit, NOT on the hospital charges.

Why would I receive a bill from other physicians or departments?

Some visits also have charges due to consults or ancillary services in other departments (e.g., Rheumatology, Pharmacy, Pathology, etc.). Biopsies are a common procedure in Dermatology and will have corresponding pathology charges.

(continued on reverse)

Why would I be charged a copayment for services during a post-procedure (i.e., suture removal) visit?

Copayments are set amounts you pay when you go to a health care provider. Providers usually collect copayments at the visit. Copayment amounts are listed on your health insurance card.

If the provider addresses additional health issues that you may have, an additional visit code might be billed and your insurance may apply a copayment to this part of the visit. The staff do not know at the time of check in what services will be provided during your actual visit, as this is between you and your provider. If there is a copayment you will be billed.

What is a deductible?

Deductibles are the yearly expenses you pay before your health insurance pays anything. For example, each year you pay the first $1,000 of your health care bills before your health insurance pays anything.

What is a referral?

Approval needed for care beyond that provided by your primary care doctor or hospital. For example, managed care plans usually require referrals from your primary care doctor to see specialists or for special procedures. Administrative referrals require minimal clinical information (i.e., diagnosis) and clinician involvement for the approval process.

What is an Explanation of Benefits (EOB)?

An EOB is the notice you receive from your insurance company after getting medical services from a doctor or hospital. It tells you what was billed, the payment amount approved by your insurance, the amount paid or denial reason, and what you have to pay.

What are the Dermatology hospital based practices?

- Brigham Dermatology Associates at 221 Longwood Avenue, Boston
- Brigham Dermatology Associates at 850 Boylston, Chestnut Hill
- Mohs and Dermatologic Surgery Center, Jamaica Plain
- Fish Center for Women's Health at 850 Boylston, Chestnut Hill

When will I receive a bill?

Patients are billed as soon as possible after their provider's appointment or hospital stay.

- Typically, bills are not sent until all insurance claims have been processed.
- Patients without insurance receive bills directly.
- Bill cycles are every 30 days.
- Once a bill is received, patients are given 25 days to pay their bills in full; the due date will be noted on your bill.

How can I pay my bill?

1. Pay your bill online at www.patientgateway.org
2. Call **617-726-3884** and press **1** to pay your bill by phone
3. Send a check or money order to **Partners HealthCare System, P.O. Box 418393, Boston, MA 02241-8393**