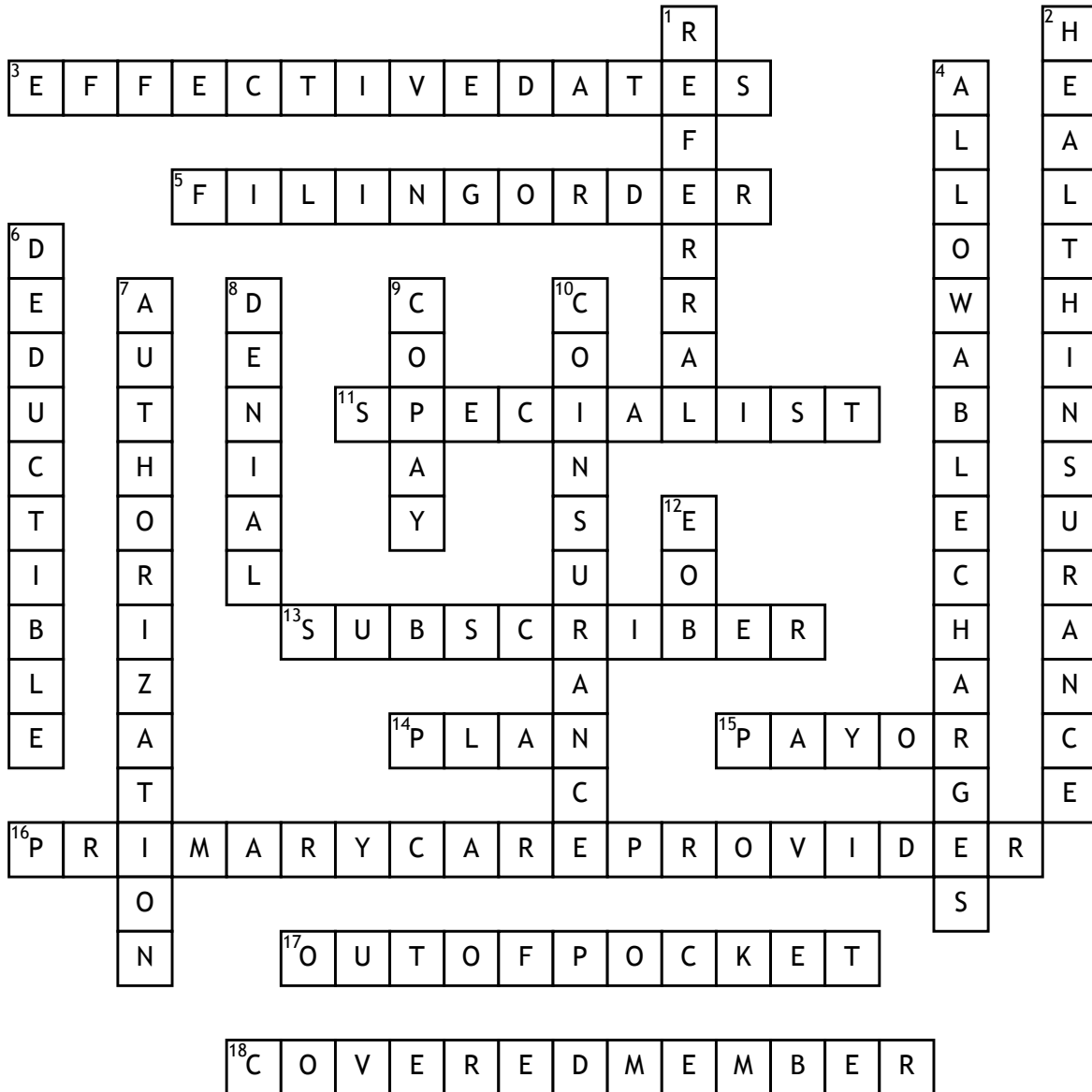


Healthcare Vocabulary



Across

3. Dates during which the insurance plan is active.

5. The order in which the claim is sent to insurance companies. If patient has more than one insurance plan, we must determine which insurance should be billed primary, secondary, etc. Primary: the first insurance company designated to pay toward their allowable charges. Secondary: the second insurance company designated to pay toward their allowable charges.

11. A provider who focuses on one area of medicine. Like a cardiologist or neurologist

13. The person who is responsible for payment of the monthly premium, or whose employment is the basis for the coverage.

14. A specific package of benefits negotiated between the company and the employer.

15. Insurance Company

16. Referred to as family doctor/PCP this person administers routine and preventive care, and makes referrals for specialty services when needed.

17. Annual maximum amount patient is required to pay for in-network medical services per his/her insurance plan contract (typically, copay + coins + deductible)

18. A person entitled to health insurance benefits under the subscriber's plan.

Down

1. The pathway a patient takes from one provider to another. Referrals may be required by insurance before a patient can be seen by the other provider.

2. A contract with a company where the subscriber pays a regular premium in exchange for a defined set of benefits

4. The contracted rate a health insurance company will pay toward a specific medical service.

6. A pre-determined annual amount patient must pay before insurance begins to cover.

7. The process whereby a physician must obtain insurance approval before a patient receives certain treatment or drugs (study, test, procedure, surgery.)

8. /Response from the insurance company that states no payment will be made. (service could be not covered by the insurance plan, or the insurance company may need more information.)

9. A contracted, pre-determined dollar amount insurance company requires a patient to pay for a particular medical service. (It requires patients to pay a small amount upfront to deter people from seeking medical care that may not be necessary.)

10. A contracted, pre-determined percentage of the allowable charge that a patient is required to pay for a particular medical service (after the deductible is met and before the out-of-pocket maximum is met).

12. Explanation of Benefits is a statement from the insurance company that details payments and adjustments made for services. EOBs go to both the provider and the patient.