BILLING AND INSURANCE

Q. What do you mean when you say you will accept assignment?
A. Taking assignment with insurance or Medicare means that we are willing to accept the amount they allow for a specific product, that we file the claim, and that we are paid directly by the insurance company or Medicare for the percentage that your individual policy states. Medicare is 80%/20%, so if Medicare allows $100 for a covered product, they will pay us directly for 80% of their allowed amount, or $80. Your responsibility will be 20% or $20. If your insurance policy is 70/30, this means they will pay us 70% of their allowed amount and your responsibility will be 30%, etc.

Q. How will you accept assignment on my online purchase?
A. Currently, online providers require you to speak to one of their representatives for assigned claims. We have made it possible to accept assignment online. Go ahead, shop online and put all the products you desire in your cart. Check the **Accept Assignment** box at checkout. This will put your cart on hold for 24-72 hours while we complete the eligibility and benefits process and determine what and how much your insurance will allow for the products you have chosen. We will notify you by email that a discount has been applied to your cart for the amount your insurance should pay us. You will then go to your Cart and at checkout, you will only pay the difference of your total cart balance and what your insurance will be paying us directly.

Q. How do I purchase a prosthesis and bras online for you to file my claim assigned?
A. We want your online mastectomy purchase to be just like our in-boutique purchases, so we have

Q. Does my insurance policy cover wigs?
A. Each insurance plan is different, and many do not allow coverage for wigs, but we have some contracts that do allow coverage, such as Aetna. As a courtesy we will be happy to verify your benefits. Be sure to have your insurance card and driver's license handy when you arrive. If you want to verify your own policy for coverage, call your insurance company and ask if your plan allows A9282, Cranial Prosthesis. Please write down the name of the person you spoke with, the date and time, and ask for a Reference Number for the call.

Q. Will my health insurance cover post-mastectomy products if I had breast reconstruction?
A. Yes, your health insurance should cover bras, breast prosthesis, breast forms and camisoles whether you had breast reconstruction if they are medically necessary. If you find your breast reconstruction as unfavorable, or has left you un-symmetrical, your insurance should cover a breast prosthesis overlay or partial prosthesis for a more symmetrical look. As a courtesy we will be happy to verify your benefits.

Q. How often will my insurance allow mastectomy products.
A. Medicare, Medicaid, and most commercial insurance plans allow silicone prosthesis every two years, foam prosthesis every six months, and 2-4 mastectomy bras per year. However, these can be replaced as needed, when medical necessity is documented due to weight loss, weight gain, or products are lost or stolen, or irreparably damaged.

Q. Does Medicare cover a compression sleeve for my arm?

A. Medicare does not cover a compression arm sleeve. However, we are diligently working with Congress to pass the Lymphedema Treatment Act, which would mandate Medicare to cover these medically necessary garments. Click here for more information about how you can help get the *Lymphedema Treatment Act* passed in Congress. *(Include link to the LTA)*

Q. Does Medicare cover compression garments for my legs?
A. Currently Medicare does not cover any compression garments for lower extremities. However, if you have an open wound or sore that is being treated by a physician, Medicare will cover knee high compression hose as a "surgical dressing." Even then, Medicare will not NOT cover compression hose if you have Home Health coming into your home, as the Home Health Agency is responsible for providing all needed "surgical dressings."

Q. Will my insurance cover a custom prosthesis?
A. Many insurance plans, including Blue Cross Blue Shield, United Healthcare, Cigna Healthcare, and most Medicaid plans will cover a custom prosthesis when medical necessity is met. Most all Aetna plans follow Medicare guidelines and consider them cosmetic and not medically necessary. Call the Women's Health Boutique nearest you and ask for a Mastectomy Fitter. We will check your your insurance benefits to see if a custom prosthesis is covered under your plan.

Q. Will Medicare cover a custom prosthesis?
A. No, unfortunately Medicare considers a custom prosthesis and cosmetic and not medically necessary. Most of the Medicare advantage plans and some insurance plans are now following Medicare guidelines too concerning non-coverage of a custom prosthesis.

Q. How often will my insurance allow me to get a new custom prosthesis?
A. Most insurance plans will cover a custom prosthesis every two years unless medical necessity requires one sooner.

Q. What do I need to do for you to file my claim?
A. To file your claim for products covered by your insurance, we will need your complete insurance information and a prescription from you doctor or Primary Care Physician if your insurance requires that.

Q. How do I know if my insurance is in network with you and if they cover products I am requesting?
A. The most accurate information will be for you to contact your insurance provider directly. Please see our In-Network Insurance List to see if your company is listed. We will work with you and your insurance to verify your benefits and see if the products you need are covered under your plan.

Q. I was told that prior authorization is required for my products, what does that mean?
A. Some health insurances may cover an item but require us to obtain authorization from them first before we submit a claim on your behalf. In that case, we will need a prescription and complete medical records from your physician in order for us to obtain prior authorization for your products.

Q. What will my cost be for products received?

A. This will depend on your insurance plan. If you have traditional Medicare, your cost will be 20% of the Medicare allowable after the deductible has been met. If you have Medicare and a supplement plan, you may not have any out of pocket expense. Your out of pocket for all other insurances will be based on your actual plan coverage, whether you've met your deductible and/or out-of-pocket, and product upgrades. Medicaid plans all pay at 100% so your cost will be $0. Also, most breast pumps are paid at 100%, with no deductible or copay.

Q. What is the difference between deductible, out-of-pocket and co-insurance/copay?

A. Most insurance plans have a deductible amount that you must pay before they will begin paying your claims. Once your deductible has been met, they will begin paying according to your policy. Example: Your policy will pay 80% of allowed charges once your deductible has been met. The remaining 20% will be your responsibility, which is your Co-Insurance amount. Most insurance will also have an Out of Pocket amount, which means when you've met that amount, your insurance will pay 100%.

Q. What if I have multiple insurances?

A. If you have multiple insurances, you will need to let us know. Claims are filed to the primary insurance first and then to any additional insurance policies you may have. If we do not have the correct policies, it may become your responsibility for any balances due.

Q. I have a Medicare Supplement Policy, will I still have to pay anything?

A. That depends. Some supplement policies will not pay for Medicare deductibles, leaving that amount your responsibility. Most supplement policies will cover the 20% remaining once Medicare has paid but you could still be subjected to out of pocket expense if your policy requires a deductible to be met first, if Medicare does not pay, or if your supplement covers only part of the 20%.

Q. What happens if the insurance pays you after I do?

A. We collect your Co- Insurance amount, and Deductible if it has not been met, at the time of service. On an assigned claim, once the claim processes, if your EOB states that your "patient responsibility" is less than what you have paid, then we will issue you a refund for the difference.

Q. What if my insurance doesn't pay?

A. If your insurance doesn't pay and leaves the balance due to your responsibility, we will send you an invoice with several payment options: Pay by credit/debit card, send personal check, or request to be set up on a payment plan. You can call our Billing Department to have a payment plan set up or pay by phone with your credit/debit card.