Medical Claim-Aid

The following describes our policies and procedures for various claims.

MEDICARE CLAIMS

Medicare claims are electronically processed and all insurance companies and individuals are billed weekly. The invoices are sent on a weekly rotating basis, with each patient billed monthly. Medical Claim-Aid coordinates all benefits between Medicare and insurance denials, providing additional information as required by the insurance companies and requests hearings as necessary. Payments are posted upon receipt and sent to you weekly along with a detailed credit report. Medical Claim-Aid invoices the client the contractual contingency amount monthly for all receipts received the previous month.

PAYMENTS AND PAYMENT INFORMATION

Payments can be sent to you, the client or to Medical Claim-Aid, whichever you prefer. If payments are sent directly to Medical Claim-Aid, a post office box will be opened for that specific purpose. This option is certainly the least complicated for your company. To alleviate information and payment loss, all insurance informational requests, denials, returned mail, payments, etc. are sent directly to your post office box in Denton, MD. All payment information will be posted and payments will be forwarded to you weekly with a detailed credit report. No payments are ever deposited here.

REPORTING CAPABILITY

Medical Claim-Aid can provide many standard and individualized reports, according to your company's needs. These reports can be provided at your direction, either monthly, quarterly, annually or all of the above. Additionally, specific reports can be provided upon request, many of which can be generated and sent to you within minutes of your call.

The standard reports we supply are as follows:

- Call Report - detailed or summary. This report can be as specific as you wish (i.e., - listing all patients transported on a specific day, week, etc. or just total calls by call type (ALS, BLS, fire/rescue). A detailed call report is at least monthly to insure accuracy.
- Credit Report - Details the payments by payment type, date received, etc. credit reports can also be generated specifically to show write-off amounts (insurance discounts, hardship, etc.).
- Charge Report - Details charges by charge type (ALS, BLS, Mileage (if applicable), level of fire/rescue, etc.)
- Numerous financial reports, including: receivables, aging, receivables distribution, and patient collection report.

AMBULANCE PROVIDER REQUIREMENTS

As your partner in the ambulance billing process, Medical Claim-Aid must have certain requirements met to provide the best services to you. Your company will need to provide:

- A commitment to the success of your billing program, including addressing any problems, questions or concerns to Medical Claim-Aid immediately for prompt resolution.
- Initial set up information, including federal identification number, tax exempt number, and current provider numbers with Medicare, Medical Assistance and other insurance companies. New ambulance providers must provide additional information for Medicare and Medical Assistance initial applications
- An informed and available liaison for verifications and receipt of additional necessary information.
- Accurate and legible runsheets (original or legible photostatic copies of MAIS reports with additional narrative).
- If payments are not mailed to us, you must provide all payment and related information. Original Medicare remittance advices; explanations of benefit from all insurance companies, including denials and requests for additional information; returned mail, copies of all personal payments from patients. All payment information must be sent on a regular (preferably weekly) basis.
- Copy of hospital face sheet, whenever practical.
- Education and training of volunteers on compliance issues, including obtaining signatures from patients, and the billing program in general.
- A current copy of any ambulance subscription plan.
- A signed billing agreement with Medical Claim-Aid.