Balance Billing

Billing the Member

Providers may bill a patient under any one of the following circumstances:

- The member misses an appointment
- The member owes a copayment amount
- The member owes a co-insurance amount
- The member owes a deductible amount
- The service is not covered by the member’s plan
- The provider does not participate in the Anthem provider network
- Anthem denies the services because they are experimental and investigational, not medically necessary, or not referred and the member signed a waiver form BEFORE receiving the services.

Providers may not bill members for services denied because the provider failed to comply with established policies and procedures, including but not limited to completing required precertification and submitting claims within the filing time limits.

Providers may not bill members for any unpaid balance remaining when benefits coordinated between applicable health plans do not fully cover the charges.

If the copayment, coinsurance and/or deductible amount collected from the member at the time of service exceeds the actual member liability as shown on the remittance advice (RA), then the provider will be required to promptly refund to the member the amount overpaid and not apply the copayment, coinsurance and/or deductible overpayment to outstanding balances due on other unprocessed claims.

A member’s balance may be determined from provider RA. A column on the far right of the RA is labeled “due from patient” or “due from subscriber”. This amount appearing in this column is derived from copayments, deductibles and coinsurance amounts and non-covered services and is the amount that can be collected from the member.

Waiver Form

Use an Anthem Waiver or similar form for the following situations only:

- Experimental and investigational services
- Non-referred services
- Not medically necessary services

Do not bill a member for denied services unless the member signed a waiver in advance and in writing to pay for such services.
No matter which waiver form is used, the following information must be included:

- The specific services to be provided must be detailed, including dates of service, a description of the procedures or services, and the amount charged
- An acknowledgement that the member understands the services are not covered
- An agreement that the member will pay for the denied services

When submitting a claim for services that require a waiver, do not submit the waiver with the claim. If Anthem denies the service as “provider liable”, contact the provider services call center to request a review or adjustment. Fax or send a copy of the waiver form if requested.