Insurance Card Quick Reference

FRONT DESK · READ IT, DON'T JUST COPY IT

MediClaim Works
Dental medical billing

THE THREE QUESTIONS — IN THIS ORDER

1 · Medical or dental?
Different cards, payer IDs, and claim forms. Copay grid or RxBIN on the card = medical.

2 · What type of plan?
PPO, EPO, HMO, POS, Medicare Advantage, Medicaid, comp. Say it out loud, write it in the chart.

3 · Does it pay out of network?
The only question that changes money. The first two get you here.

CARD FRONT — WHAT YOU SEE, WHAT IT MEANS

WHAT YOU SEE	WHAT IT TELLS YOU
Plan type wordmark	The most important field on the card.
Member ID	Onto the claim exactly as printed, letters included.
BCBS 3-character alpha prefix	Routes to the home plan. Drop it = unprocessable claim.
Group number	Employer coverage. Possibly self-funded — check the back.
Copay grid (PCP / specialist / ER)	You are holding a **medical** card.
RxBIN · RxPCN · RxGRP	Pharmacy benefit. Medical card confirmed.
Second network logo (PHCS, MultiPlan)	Rental network. You may be repriced. Verify before quoting.
"HSA" · "HDHP" · metal tier	Deductible structure. Read the network type separately.

CARD BACK — WHERE THE CLAIM GOES

WHAT YOU SEE	WHAT IT TELLS YOU
Two claim destinations	Medical here, dental there. Sending medical to the dental address is the #1 avoidable rejection.
Electronic payer ID	What actually routes the claim. Verify in the clearinghouse list — never guess.
Provider Services phone	For what eligibility can't answer. Never Member Services.
Prior auth / precert line	Call before treatment, not after the denial.
"Administered by X on behalf of Y"	Self-funded ERISA plan. Plan document controls, not state law. Appeal: 180 days, request the SPD.
Medical group or IPA name	Authorization runs through the group, not the carrier.

STOP AND ASK

Card says Dental only
No medical coverage here. Ask for the medical card.

Network logo you don't recognize
Rental network. Verify before quoting anything.

Medicare Advantage
That plan's contract governs, not original Medicare.

Medicaid or CHIP
Verify enrollment and your state's balance-billing rule.

Two cards
Set coordination-of-benefits order now, not at claim time.

"I think it's still active"
Verify electronically, same day. Cards outlive coverage.

MediClaim Works does not review or determine claim content; diagnosis codes, modifiers, and service qualifiers are selected by the provider or billing professional. General education only — not legal, coding, or reimbursement advice. Verify current rules with the payer and your state.

Plan Type → What You Collect

FRONT DESK · OUT OF NETWORK VS. IN NETWORK

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PLAN TYPE	IF YOU ARE OUT OF NETWORK	IF YOU ARE IN NETWORK
PPO	Real benefit, paid on an allowed amount (UCR, % of Medicare, or repriced). Confirm assignment of benefits or the check goes to the patient.	Contracted fee. Write off the difference. No balance billing.
EPO	Claim denies. 100% patient responsibility — settle it in writing before the appointment.	Contracted fee. No referral needed.
HMO	Claim denies except emergency or authorized referral.	Referral + authorization required, or it denies anyway.
POS	Benefit exists at the worst tier; often needs the PCP referral.	Best rate at the in-network tier.
HDHP / HSA	Patient pays until the deductible is met. **File anyway** — the claim credits the deductible.	Same, at your contracted rate.
Indemnity	No network concept. Paid on UCR like anyone else.	n/a
Self-funded / ERISA	Plan document controls. ERISA appeal, 180 days. Request the SPD in writing.	Rented network rate.
ACA marketplace	Usually EPO or HMO underneath — verify before assuming. Metal tier ≠ network.	Watch the 90-day premium grace period.
Medicare Part B	Inextricably-linked services only; KX modifier + ICD-10 required. Enrollment status decides what you may charge.	Par: 100% of schedule. Non-par: 95%, limiting charge 115%. Opt-out: private contract.
Medicare Advantage	MA-PPO: benefit exists. MA-HMO: none. Heavy prior auth.	Dental benefit usually runs through a separate vendor.
Medigap	Pays only where Medicare paid. If Medicare denies, it denies.	Same.
Medicaid / CHIP	Generally unpayable. Balance billing for a covered service is prohibited.	Must be enrolled. Auth-heavy. Payer of last resort.
TRICARE	Non-par balance billing capped at 115% of allowable.	Prime is referral-driven; Select allows non-network.
VA Community Care	No authorization = no payment, and no billing the Veteran.	Authorization-driven.
Workers' comp	State fee schedule. Adjuster authorization first. No patient billing.	Same.
Auto Med-Pay / PIP	Pays to the limit, then stops. Get claim #, date of accident, adjuster.	Same.
Fixed indemnity	Pays the patient a flat amount. Bill normally.	Same.
Discount plan / health share	**Not insurance.** Self-pay workflow, no claim, no appeal.	n/a

BEFORE YOU QUOTE — RUN ELIGIBILITY IN MEDICLAIM WORKS

THE PULL ANSWERS THESE — IN SECONDS

1. Active coverage, and the plan's effective dates
2. Plan type and network status
3. OON deductible — the amount, and how much is met
4. OON out-of-pocket maximum
5. Coinsurance percentage by service type
6. Whether prior authorization is needed — often flagged on the pull

TWO THINGS NO PULL CAN GIVE YOU

The allowed amount
Not known until the claim processes. A coinsurance percentage is a percentage *of a number nobody has yet* — which is exactly why you never quote a dollar figure from it.

Assignment of benefits
Not a question for the payer. We select it on the claim — so it is our decision, made before submission, not something to chase afterward.

Start with the pull, not the phone. It answers the left column instantly and saves to the chart as a record you can defend — a verbal quote is not. Payer ID and claim routing come from the payer list. Self-funded or fully insured? The *card* answers that — look for "administered by" on the back. Only call when the pull leaves a gap, and capture rep name, reference number, and date when you do.

THREE RULES THAT DO NOT CHANGE

One fee schedule for every payer.
Plan type changes what gets *paid*. It never changes what gets *charged*.

Medical first, then dental.
In network with dental, out with medical? Same fee on both. File medical, then dental with the medical EOB.

The total fee is patient responsibility.
"Your plan has OON benefits" is a fact. "Your plan will pay 60%" is a promise you cannot keep.