DENIAL OF SERVICE INTAKE FORM

Last Name _____ First Name _____ Membership ID _____

Provider Information

Provider Name _____ Provider Facility/Hospital _____

Provider's Billing Contact Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Who communicated to IHS that service was denied? _____

Has service been provided? _____ Is service scheduled? _____ Is service pending? _____

Has the member made a deposit towards service? _____

Is there a treatment plan? (will this be a series of treatments, procedures, visits?) _____

Member Information

What is their PRA? _____ Has it been met? _____ Has co-share been met? _____

What is the estimated cost for the service? _____ What is their anticipated responsibility for this event? _____

Is this a Pre-existing condition? _____ Is this an eligible medical expense? _____

Communications: Please provide a summary of all communications to date.

Denial of Service Process

1. IHS needs to call the member to get all the details and specifics. We should assess the member's specific needs going forward. If the member has already received medical services, we should advise them of the reimbursement process. We should also advise them that we (IHS) are reaching out to the provider.

2. IHS to call provider and advise the point of contact of IHS' unique features and how it is uniquely constructed to pay providers promptly. Ask the hospital what is needed or remains for them to accept IHS members. To ease future billings, we should also ask them to add IHS' Payor ID to their EMR.

Possible agreed upon outcomes.
I. Hospital agrees to accept IHS members, requires no payment or deposit upfront, and bills IHS directly.
II. Hospital agrees to accept IHS members, requires a deposit upfront, and bills IHS directly.
III. Hospital agrees to accept IHS members, requires a deposit upfront, bills the Member a balance and the Member submits the bill.
IV. Hospital agrees to accept IHS members, provides a "cash pay" discount, requires full cash payment upfront, and the member submits reimbursement request.

3. Based on Hospitals response, call member back and advise about future visits to provider.