Invo Family of Companies Billing Team

Phone: 866-222-0382

Email: patientaccounts@invohealthcare.com

Frequently Asked Questions

When will I receive my first invoice after beginning services?
If the patient has health insurance, following the delivery of therapy services, claims will be sent within 30 days to the patient's insurance company for processing. Once the insurance company processes the claims, an explanation of benefits indicating charges that have been assessed to the deductible and/or out of pocket maximum is sent to Invo from the insurance company. Invo will then send an invoice by mail to the patient/guardian of the patient, with the listed patient responsibility due. *Claim processing times for insurance companies can vary and can take up to four months, especially during the Covid pandemic. Some insurance companies are short staff and behind on claim processing so extra patience during this period is necessary.

If the patient is accessing self-pay for services, invoices will be sent to the patient/guardian of the patient the following month after services were delivered.

How often will I receive an invoice?
Once a patient's first claim has been processed and your first invoice received, you will be mailed regular monthly invoices each month by the last day of the following month. Patients will receive an invoice by mail once claims are processed by the insurance company and an explanation of benefits indicating charges that have been assessed to the deductible and/or out of pocket maximum is sent to Invo. *Claim processing times for insurance companies can vary and can take up to four months.

What if I cannot pay the amount I owe in full?
In many cases, we can help establish a 6-month payment plan. Partial payments made toward your balance will not stop collection activity unless you have made payment arrangements with us. To discuss the option of a payment plan, patients/guardians of the patient should contact the billing department.

What form of payments are accepted?
Invo accepts check, credit/debit cards (Visa, MasterCard, Discover and American Express). Payment can be made over the phone 866-222-0382, accessing the online payment portal, or sending a payment by mail to the address listed on your invoice. *The online payment portal can be used for patients of any Invo Company, it is not exclusive to patients with Autism Home Support Services.

What if there is a mistake on my statement?
If a patient/guardian of the patient has any billing questions, the patient should call Invo billing department at 866-222-0382. Typical office hours are Monday – Friday 8 am – 5 pm central standard time. If you call after hours, please leave a message and your call will be returned the next business day.

Why am I being billed for my co-insurance and deductible weeks/months after the date of service?
Co-insurance and deductible amounts are applied to the patient's account when the explanation of benefits is received from the insurance company. Initial claim processing times vary by insurance company. The patient will be billed for the co-insurance and/or deductible once the explanation of benefits is received and posted to the patient's account. Invo billing department will call at least monthly to follow up with your insurance carrier to check on the status of your initial claims submission status.

When will I know when my deductible or out-of-pocket maximum has been met?
The patient/guardian of the patient is responsible for tracking the monies applied to their deductible/out-of-pocket through their review of the explanation of benefits statements sent to the patient by their insurance company. The patient should contact their insurance company to assure whether their deductible and/or out-of-pocket maximum has been met. The insurance company is processing other provider claims throughout the year and monies are being consistently applied to the deductible and out of pocket.

Why can't I pay my deductible/out-of-pocket expense up front?
As a provider under contract with the patient's insurance company (a "participating provider"), Invo is required to only bill patients after the explanation of benefits indicates an amount has been assessed to the patient's deductible/out-of-pocket.

Can INVO hold off on billing my claims, so my deductible/out of pocket can be met by my other doctor/hospital visits?
No. As a participating provider, Invo is under contract to bill claims within the time limit specified in our contract.

Why did my insurance only pay part of my bill?
Most insurance plans require the patient to pay a deductible and/or co-insurance. Patients should contact their insurance company for specific answers to their questions.

Why was my last payment divided and applied to the bill in two separate places?
INVO posts a patient's payment to the oldest charges first.

What does "adjustment" mean?
"Adjustment" refers to the portion of the patient's bill that their provider has agreed not to charge them.

What is a co-payment?
A co-payment is a set fee the patient pays to providers at the time services are provided. Co-pays are always contained in your insurance plan documents and you should research and be aware of the co-payment amounts you are responsible for prior to services being rendered.

What is a deductible?
Deductibles are provisions that require the patient to accumulate a specific amount of medical bills before benefits are provided. For example, if a patient's policy contains a $500 deductible, the patient must

accumulate and pay $500 out of pocket before the insurance carrier will pay benefits. Once the patient has met their deductible, the carrier usually pays a percentage of the bill which is called the co-insurance. The patient is liable for the unpaid balance your insurance plan does not cover. Deductibles are established on an annual basis usually starting at the start of the calendar year. Please check your specific plan design in your insurance documents so you are familiar with how and when your insurance will attach and start paying for covered services.

What is out-of-pocket?
An out-of-pocket expense is a non-reimbursable expense paid by the patient. This may include deductibles, co-insurance, co-payments, and medical benefits your health plan does not consider "covered services". An **out-of-pocket expense maximum**, or cap, is the amount the patient must meet for the insurance company to pay 100% of the policy's benefits. Please familiarize yourself with your maximum out of pocket obligations before starting services. This will ensure if the insurance carrier does not adjudicate your claim (sometimes this takes up to four months) timely, you will be aware of your total financial exposure and avoid any surprise when you receive your first invoice for services.

Why do I still owe a balance if my insurance company has paid?
Based on the patient's insurance plan, the patient may be responsible for deductibles, co-pays, and co-insurance.

What if my insurance coverage changes?
The patient must provide their Clinician (BCBA, ST, OT, PT) their new insurance card/information as soon as possible. Email a picture of front and back of your new insurance card, along with the name and date of birth of the policy holder/subscriber. All new insurance coverage must be verified by the insurance department and an authorization must be obtained under the new insurance plan. Depending upon the effective date of the new insurance and the approval time for a new authorization, there may be a brief interruption to the patient's services. If ABA Therapy is no longer a covered benefit, the insurance department will provide information on other coverage options, self-pay rates, and other resources that may be helpful in securing funding for services. Remember that the sooner your are able to provide your new insurance information, the sooner an authorization from the insurance company can be obtained and services will not be interrupted.

Why aren't all services covered by my insurance company?
Under any plan, there may be services that are not covered because the insurance company may consider them routine or unnecessary. The patient's employer may also elect not to cover certain services under the insurance. If you disagree with the decision, you should contact your insurance company or employer for more information.

What if I have more than one insurance policy?
Invo must attempt to obtain an authorization and bill all insurance companies which the patient has listed as having as active medical coverage. Insurance billing guidelines and contractual agreements with insurance companies require Invo to bill the primary insurance carrier before any secondary plans can be billed. If you have one more than one insurance, it will be important for you to understand who is the primary insurer for the services being rendered by Invo.

Which insurance policy is primary?
The insurance company has coordination of benefit rules that determine the respective payment responsibilities of each plan. Coordination of benefits helps ensure that patients covered by more than one

plan will receive the benefits they are entitled to while avoiding overpayments by either plan. If a dependent child is covered under two or more plans, the plan of the member covering the child whose birthday occurs earlier in the calendar yearwill be primary (known as the birthday rule). If both have the same birthday, the policy that has been in effect longer will be primary. The birthday rule is superseded when a court order or custody rule applies.

My previous ABA provider told me that I did not have to pay my deductible and/or co-pays. Why do I have to with INVO?

As a participating provider, INVO has a contractual obligation to request payment from the patient for their deductible, co-pay, and/or co-insurance. Invo is not permitted to waive deductibles or co-pays.