MORE QUESTIONS?

Thank you for choosing PeaceHealth as your health care provider. If you have any questions regarding Provider-Based billing, please feel free to contact us.

877-202-3597
**This Clinic is a Provider-Based Facility**

You are receiving care from a clinic that is a department of the hospital and has received approval from Medicare to bill for services as a Provider-Based facility. This means we will bill Medicare separately for professional and facility services; you may receive two bills and you will be responsible for the related co-payments according to your coverage.

**What does “Provider-Based” mean?**

This is a special Medicare designation for hospitals and clinics that comply with specific regulations. This designation allows clinics to bill Medicare and collect for both a professional fee and a facility fee for their services. Medicare has determined that this clinic has met these regulations.

**How does Provider-Based affect my billing?**

Medicare requires Provider-Based facilities to bill all health care provider services in two parts. When your medical services are completed, we will submit two claims to Medicare:

- Facility fee - Part A
- Health care provider fee - Part B

You will receive two Medicare Summary Notices from Medicare. Once Medicare has processed its portion of the charges, the balance will be submitted to a secondary payor. If there is a balance after the secondary insurance processes the claim, or if you do not have a secondary insurance, you will be billed for each of the remaining balances.

*Please note: The total cost of charges for Medicare patients will not exceed charges incurred by non-Medicare patients receiving the same services.*

**Estimate of Coinsurance Amounts**

Medicare requires that we provide you an estimate of your Part A and Part B coinsurance amounts. The actual amounts will vary based on the type, number of services received and any secondary insurance you might have.

<table>
<thead>
<tr>
<th>Service</th>
<th>Part A</th>
<th>Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>$11–$17</td>
<td>$12–$27</td>
</tr>
<tr>
<td>Radiology</td>
<td>$20–$40</td>
<td>$2–$12</td>
</tr>
<tr>
<td>Minor Procedure</td>
<td>$10–$50</td>
<td>$5–$10</td>
</tr>
</tbody>
</table>

**Why does the Medicare Secondary Payor questionnaire need to be completed?**

As a participating Medicare provider, we are required to screen Medicare patients according to the Medicare Secondary Payor (MSP) rules. At each visit, a business services representative will ask you the MSP questions. These questions will help to confirm if Medicare should process the claim as your primary insurer.