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Manish Bhuva, MD
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GI PARTNERS of ILLINOIS, LLC

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James Ferguson, CNP
Katie Akers, CNP

Patient: _____ DOB: _____ Procedure Date: _____

Doctor: _____

As a courtesy we pre-authorize every procedure, both screening and diagnostic. This means we call your insurance company to notify them of your upcoming procedure and its medical necessity. If there are problems with this process, we will call you to let you know. We do not check your coverage.

Your insurance company may not cover your procedure if your policy does not have routine, wellness or screening benefits. For example, some insurance companies are not approving payment for a colonoscopy or EGD done for the purpose of routine/age screening for colon cancer, or even if you have a family history of colon cancer, esophageal cancer or Barrett's esophagus. Patients must call their insurance company's customer service or benefits department to inquire as to any coverage in these cases.

If your policy does have routine or wellness benefits, you will want to check on the amount allowed in your policy.

Some insurance companies that do have screening benefits only cover a small portion of the cost. For instance, your policy may allow between $100.00 to $500.00 maximum yearly for preventative care, while the charges for an outpatient procedure can sometimes run $4500.00 with doctor, hospital, & lab fees. You will be responsible for any outstanding charges.

There have been times when a screening procedure results in a "**finding"**. It is the policy of some insurance plans to now process these claims as diagnostic and not as screening, resulting in payment under a different fee schedule. This determination is out of our control and any dispute in this area must be between you and your insurance company.

It is our hope that the information on this page will help you to ask your insurance company appropriate questions regarding your coverage prior to your procedure and thereby prevent any misunderstandings

** Please check benefits for Anesthesia

It is the patient's responsibility to confirm benefits, verify in-network doctors and facilities for **both** diagnostic and screening procedures. Should the Doctor or Facility not be in your network, **you will be responsible for any charges not covered by your insurance.** (This includes labs, Ct-Scans, radiology and supplies.)

We require a 48-hour notice for cancellation or rescheduling of procedures. Failure to provide the 48-hour notice may result in a $250.00 fee being assessed.

PLEASE CALL YOUR INSURANCE COMPANY (or Human Resource Department at your place of employment) for this information. The phone number is usually found on the back of your card. Most insurance companies can be accessed online. **Please sign, date and return this form to our office.**

- I understand that I am responsible for any charges my insurance company does not cover.
- I understand that if my unpaid balance has to be placed with a collection agency a 35% fee will be added to my balance to cover their fees.
- I understand that my procedure cannot be coded a Routine Screening if I have a Personal History of Colon Polyps, Personal History of Colon Cancer, or a Sign or Symptom.

_____ _____

Sign **Date**

_____

Print Name

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FREQUENTLY ASKED QUESTIONS

What is the definition of a screening (routine) colonoscopy?

Most insurance companies define a screening colonoscopy as:

- A first-time colonoscopy after the age of 50 (with **no** GI symptoms)
- 10 years prior to the age of a 1st degree relative (mother, father, or sibling) having been diagnosed with colon cancer (high risk screening). **Patients under the age of 50 years must check with their insurance carrier to determine if and how a high-risk preventative screening is covered.**

What if a problem is found during the screening (routine) colonoscopy?

If a procedure is billed as a screening (routine), most insurance companies will assume that the colonoscopy benefits should be applied based on the intent of the test (i.e. routine screening) and not the findings. In the event that during the screening colonoscopy a problem is found (such as a polyp), we cannot guarantee that the colonoscopy will be covered 100%. Patient benefits and claim payments are at the sole discretion of each individual insurance company. **Each patient is strongly encouraged to know their insurance benefits prior to any test/procedure by directly contacting their insurance carrier.**

When a "finding" is present during a screening (routine) colonoscopy, a patient may be responsible for the following charges:

- Pathology expenses
- Anesthesiology (please be sure to verify benefits and participating providers)
- Outpatient facility fees (Barrington Clinic and/or possible out-of-network hospitals)

Not everyone is medically eligible for a screening (routine) colonoscopy. When is a colonoscopy NOT a screening (routine) colonoscopy?

- When a follow-up colonoscopy is performed on a patient with a history of polyps that were removed during a previous colonoscopy
- When there is an abnormal finding with a CT-scan
- When there are GI symptoms such as; change in bowel habit (diarrhea or constipation), rectal bleeding, blood in stool, anemia, history of Crohns Disease, Ulcerative Colitis, post diverticulitis, weight loss or abdominal pain

Guidelines based on the Healthcare Reform Laws

****An EGD is never done as a screening procedure; it must have a medical diagnosis to be scheduled.**